IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

JENNIFER BRADLEY	*	
Plaintiff	*	
v.	*	**Case No: 1:16-CV-00346 (RBW)** **Judge Reggie B. Walton**
NCAA, et al	*	
Defendants	*	

DEFENDANTS AMERICAN UNIVERSITY, MARYLAND SPORTS MEDICINE CENTER, DAVID L. HIGGINS, M.D., AND DAVID L. HIGGINS, M.D., P.C.'S MOTION FOR SUMMARY JUDGMENT

COME NOW the Defendants, THE AMERICAN UNIVERSITY, by and through its counsel, John J. Murphy, Esq., and Walker, Murphy & Nelson, LLP and MARYLAND SPORTS MEDICINE CENTER, DAVID L. HIGGINS, M.D., and DAVID L. HIGGINS, M.D. P.C., by and through their counsel, Kenneth Armstrong, Esquire, Robert C. Maynard, Esquire, and Armstrong, Donohue, Ceppos, Vaughan & Rhoades, Chartered and, pursuant to the Federal Rules of Civil Procedure, hereby file this Motion for Summary Judgment, and in support thereof states as follows:

1. This instant action arises out of an alleged head injury sustained by Plaintiff on September 23, 2011, while voluntarily participating in women's collegiate field hockey. On April 12, 2017, this Court dismissed Plaintiff's claims against AMERICAN UNIVERSITY with the exception of her negligence and medical malpractice claims. *See, ECF 36.* Having now completed discovery, it is clear that AMERICAN UNIVERSITY met its legal duty owed to the Plaintiff and that its training staff were not providing health care such that summary judgment is warranted.

2. In addition, prior to joining American University Women's Field Hockey team, Plaintiff signed multiple "Concussion Statements" and "Acknowledgment of the Risk" releases wherein she acknowledged the risk of "head injury or concussion" and agreed to hold the

Defendants harmless. *See, Concussion Statement and Acknowledgement of Risk Form, attached hereto as* **Exhibit 1** and **Exhibit 2.** Summary judgment is, therefore, warranted.

3. Further still, the opinions of Plaintiff's medical experts fail to comply with *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 592-593 (1993), such that absent an admissible medical causation opinion, these Defendants are entitled to summary judgment.[1]

4. Finally, it is undisputed that David L. Higgins, M.D. had no physician-patient relationship with the Plaintiff following the alleged head injury sustained by the Plaintiff on September 23, 2011. As such, he is entitled to summary judgment.

WHEREFORE, the above-premises considered, and as is set forth more fully in the accompanying Memorandum of Points and Authorities, which is incorporated herein by reference, it is respectfully requested that this Honorable Court:

1. Grant this Motion for Summary Judgment; and
2. For such other and further relief as this Court deems just and appropriate.

Respectfully submitted,

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[1] These Defendants have eliminated certain arguments in an effort to comply with this Court's September 24, 2019 Order and the 45 page limitation on Memorandum imposed by LCvR7(e). *See, ECF 112.* Should Plaintiff's case survive summary judgment, Defendants seek leave of Court to file Motions in Limine on the alleged liability of Sean Dash and Coach Jennings in advance of trial (which has not yet been scheduled). *See, ECF 74, 76 and 85.* Depending on this Court's ruling on pending dispositive motions, additional Motions in Limine may be warranted, as well.

REQUEST FOR A HEARING

The Defendants hereby request a hearing on all issues raised herein.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing Motion for Summary Judgment was served electronically this 31st day of October, 2019 to:

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[2] Pursuant to this Court's General Order 10(g) directing that "[e]xhibits shall be edited properly to exclude irrelevant material and to direct the Court's attention to the pertinent portions thereof" excerpts of deposition transcripts have been highlighted and page numbers referenced in the Motion / Memorandum. *See, ECF 46.* Insofar as Plaintiff suggested in prior pleadings that Defendants' references to the testimony of her primary experts, Dr. Cantu and Dr. Vollmar, amounted to "snippets of testimony [that] misrepresents the testimony", their entire transcripts are attached with the relevant portions still highlighted and page references in the Motion / Memorandum. *ECF 84 at p. 6.*

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

JENNIFER BRADLEY,	*	
Plaintiff	*	
v.	*	**Case No: 1:16-CV-00346 (RBW)**
NCAA, et al	*	
Defendants	*	

MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

The Defendants, THE AMERICAN UNIVERSITY, by and through its attorneys, John J. Murphy, Esq., and Walker, Murphy & Nelson, LLP, and MARYLAND SPORTS MEDICINE CENTER, DAVID L. HIGGINS, M.D., and DAVID L. HIGGINS, M.D. P.C., by and through their counsel, Kenneth Armstrong, Esquire, Robert C. Maynard, Esquire, and Armstrong, Donohue, Ceppos, Vaughan & Rhoades, Chartered, hereby submit the following Memorandum of Points and Authorities in Support of their Motion for Summary Judgment.

STATEMENT OF UNDISPUTED MATERIAL FACTS

1. This case arises from Plaintiff's alleged head injury following her voluntary participation as an adult student athlete at The American University.[3] *See, generally, Amended Complaint.* As averred in her own Amended Complaint, she was an experienced field hockey player and aware the sport involved physical contact without protective head gear. *Id.*

[3] Nothing contained herein should be deemed an admission that the Plaintiff did, in fact, sustain a concussion and/or that she developed post-concussion syndrome. These allegations are disputed but shall be assumed true as pled for purposes of this Motion, only.

2. Prior to the events in question, Plaintiff signed a "Concussion Statement" expressly acknowledging that "I further understand that there is a possibility that participation in my sport may result in a head injury and concussion" and that "[a] concussion is a brain injury, which I am responsible for reporting to my sports medicine staff." *See, 2011-2012 Concussion Statement, attached hereto as* **Exhibit 1.**

3. Prior to the event in question Plaintiff also signed an additional "Acknowledgment of the Risk" regarding the risk of head injuries in field hockey, agreed to fully report any problems related to physical injury to University personnel, and agreed that she was "willing to assume responsibility for any and all such risks of injury while participating." *See 2011-2012 Acknowledgment of Risk, attached hereto as* **Exhibit 2.**

4. According to the Plaintiff, she believes she sustained a concussion during a Richmond field hockey game on September 23, 2011. *Id. at ¶ 98.* As she describes it, the injury allegedly occurred from contact that was "no more extreme than other hits routinely suffered while playing field hockey." *Id. at ¶ 98.*

5. Immediately after sustaining the alleged concussion during the Richmond game, Plaintiff described feeling "a little bit out of it." *See J. Bradley's Depo at 44:18-44:22, attached hereto as* **Exhibit 3.** Plaintiff did not, however, report her symptoms to University personnel and participated in subsequent field hockey practices and games. *Id. at 46:4 – 46:17.*

6. Two days after allegedly sustaining a concussion, Plaintiff played in a game against Boston College and purportedly had problems with vision, concentration, and fatigue but again did not report her symptoms to University personnel. *Id. at 48:23 – 50:3.*

7. On October 1, 2011, Plaintiff participated in a game against Lehigh, still not having reported her symptoms to American personnel. *Id. at 51:11 – 52:23.* Although not a "material"

factual dispute, Plaintiff believes she first reported her symptoms to University personnel after the October 1st Lehigh game, whereas records from American University indicate she first reported her symptoms following a field hockey game on October 2, 2011. *Id. at 51:11-52:23.*

8. Regardless of whether initially reported on October 1st or 2nd, it is undisputed that Plaintiff waited over one week to report her symptoms to University personnel and during that period she participated in daily practices and at least two additional field hockey games. *Id.*

9. Upon learning of Plaintiff's concussion-like symptoms, Jenna Earls of the American University training staff set up an appointment for Plaintiff to be evaluated by the team physician, Dr. Aaron Williams, on October 5, 2011.[4] *Id.* at 62:11-64:6.

10. Plaintiff never saw Dr. David L. Higgins as a patient at any time after the September 23, 2011 field hockey game. *Id.* at 199:6-9.

11. According to Plaintiff's experts, Dr. Robert Cantu and Dr. William Vollmar, the negligence claim against American University arises from the alleged failure to prohibit Plaintiff from participating in field hockey from the date Plaintiff reported her symptoms until October 5th, when she was examined by Dr. Williams.[5] *See Dr. Cantu's Deposition Transcript at 44-47; 91:14-91:18, 123:5-123:10, attached hereto as* **Exhibit 7**; *See also, Dr. Vollmar's Deposition Transcript at 35:21-38:16, attached hereto as* **Exhibit 8**. Dr. Cantu conceded "that the athletic training staff at American University evaluated Jennifer and put her through a reasonable assessment for an athletic trainer… and it was reasonable that they did refer Jennifer to Dr. Williams." *See, Exhibit*

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[4] Dr. Williams was an employee of the United State of America at all times relevant hereto, working under Dr. David L. Higgins at American University through a fellowship in sports medicine through the National Capital Consortium. *See* Dr. Williams' Deposition Transcript at 23:5-24:14, attached hereto as **Exhibit 4** and Memorandum of Understanding, attached hereto as **Exhibit 5**. Dr. Higgins at all times relevant hereto was an orthopedic surgeon and independent contractor serving as American University's team physician. *See* Dr. Higgins' Deposition Transcript at 11, 53, attached hereto as **Exhibit 6**.

[5] For purposes of this Motion, only, the opinions of Plaintiff's experts shall be assumed true. As set forth in this Defendant's Rule 26(a)(2) expert disclosure, American University vehemently contests any and all claims of negligence, causation and damages.

7 at 45:10-45:20. Further still, Dr. Cantu opined it was proper for the American training staff to defer to Dr. Williams after October 5th because "the athletic trainer does work under Dr. Williams." *Id.* at 46:4-47:8.

12. According to Plaintiff's experts, Dr. Cantu and Dr. Vollmar, the negligence claim against Maryland Sports Medicine, David L. Higgins, M.D., and David L. Higgins, M.D., P.C., arises from the alleged negligence of Dr. Williams on October 5, 2011 and October 12, 2011.

13. After October 12, 2011 into early 2012, Plaintiff was seen by multiple private health care providers not party to this litigation, including her primary care provider, who despite the same information provided to the named Defendants, did not diagnose the Plaintiff with a concussion. *See, Amended Complaint at ¶ 116-118.*

14. Dr. Vollmar, testified that even if Plaintiff had promptly reported her symptoms and American University held her out from further participating in field hockey, her condition may still be as severe as she currently alleges "because once the hit was done, the damage was done." *See Exhibit 8 at 117:11-118:12.* Dr. Vollmar further conceded that he has had patients that were promptly diagnosed with concussions and held out of participation in sports but still developed post-concussion syndrome. *Id.* at 12:3 – 12:14. When asked whether Plaintiff, specifically, would still have developed post-concussion syndrome had she never played field hockey again after sustaining the initial alleged hit on September 23, 2011, he responded "[I]t's impossible to answer that question from a clinical standpoint." *Id. at 120:17 – 121:6.*

15. Similarly, when Dr. Cantu was asked whether rest in the first week after a concussion increases the chance of avoiding a permanent post-concussion injury, he responded "I don't think we know the answer to that." *See, Exhibit 7 at 56:11-58:1.*

LEGAL ARGUMENT

The standard for a motion for summary judgment, set out in Rule 56 of the Federal Rules of Civil Procedure, is no doubt a familiar one to this Court. A motion for summary judgment is appropriate when "there is no genuine issue as to any material fact" and "the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). The granting of a motion for summary judgment "is properly regarded not as a disfavored procedural shortcut, but rather as an integral part of the Federal Rules as a whole, which are designed to secure the just, speedy and inexpensive determination of every action." *Celotex Corp. v. Catrett,* 477 U.S. 317, 327 (1986)(internal quotation marks omitted). For the reasons set forth more fully *infra,* after applying this standard to the undisputed facts in the case at bar, the law is such that the Defendants are entitled to judgment as a matter of law.

1. American University Is Entitled To Judgment On Plaintiff's Negligence Claim and Medical Malpractice Claim.

A. The Negligence Claim

This Court denied American University's Preliminary Motion to Dismiss without expressly addressing the legal duty owed to a college student athlete opting, instead, to apply a general foreseeability standard until a full record was developed. *ECF 36, Order at p. 44.* Post discovery, with a full record developed, it is clear that Plaintiff's fanciful allegations are not supported by the actual facts and American University is entitled to summary judgment as a matter of law.

a. *General Duty Of Care Owed To College Students*

This Court's analysis should begin with a stark, often-quoted, recognition years ago by the Third Circuit Court of Appeals; "the modern American college is not an insurer of the safety of its students." *Bradshaw v. Rawlings*, 612 F.2d 135 (3rd Cir. 1979). More than four decades ago Supreme Court Justice Douglas recognized "[s]tudents who, by reason of the Twenty-sixth

Amendment, become eligible to vote when 18 years of age are adults who are members of the college or university community." *Healy v. James*, 408 U.S. 169, 197, 92 S. Ct. 2338, 2354, 33 L. Ed. 2d 266 (1972) (Douglas, J., concurring). Foreshadowing future debates such as the one presented in the case at bar, the *Bradshaw* court recognized that "students vigorously claim the right to define and regulate their own lives" and after a careful analysis balancing the interests of a collegiate institution compared to its students, found the college in that case had no duty to protect a student injured by an off-campus drinking-and-driving accident. 612 F.2d at 140. *Accord, Coghlan v. Beta Theta Pi Fraternity*, 133 Idaho 388 (Idaho 1999) (holding Idaho universities did not have a special relationship creating a duty to aid or protect adult students from the risks associated with voluntary intoxication); *University of Denver v. Whitlock*, 744 P.2d 54 (Colo. 1987) (concluding no special relationship giving rise to a duty by a university to protect members of fraternities and sororities from risks attendant to extra-curricular activities); *Beach v. Univ. of Utah*, 726 P.2d 413 (Utah 1986) (finding no duty on part of university to protect student injured after becoming intoxicated).

As recently as 2015, two additional jurisdictions have considered whether some "special relationship" exists between a college and its students and rejected any such relationship in both cases. *See, Nickel v. Stephens Coll.*, 2015 Mo. App. LEXIS 934, 24-25 (Missouri 2015) (observing "the general principle that no special relationship exists between a college and its students even when it comes to matters of safety.) (*citations omitted*). *See, also, Doe v. Va. Wesleyan College*, 90 Va. Cir. 345, 358 (Va. Cir. Ct. 2015) (finding "as a matter of law, that the college/student relationship does not constitute a special relationship that would impose a duty" on the college to protect a student.") (*citations omitted*). Stated broadly, post-*Bradshaw* Courts have not been

inclined to find that institutes of higher education owe a special duty to their students on account of their status as adults in society.

b. *Duty Of Care Owed In The Student-Athlete Context*

While the above-cited cases deal with the relationship between institutes of higher education and their students in general, courts have also grappled with what legal duty, if any, is owed to student athletes. A review of the law in the District of Columbia has revealed no precedent addressing what duty exists in the student-athlete context. The closest case on point in the District is *Breheny v. The Catholic University of America*, 1989 U.S. Dist LEXIS 14029 (D.D.C. 1989), where a college student injured herself during an intramural touch football game. Not only did that court find the plaintiff's claim barred as a matter of law by her assumption of the risk, the court found that the plaintiff "made no showing that Catholic University should be held to a standard of care beyond that of the ordinary landowner." *Id.* Essentially, that court viewed the case as one of premises liability, not one involving some special duty owed to the adult collegiate student. *Accord, Murphy v. Schwankhaus*, 924 A.2d 988 (D.C. 2007) (finding no duty owed by building owner to injured plaintiff who fell on sidewalk). *See, also, Burke v. Ski America, Inc.*, 940 F.2d 95 (4th Cir. 1991) (finding no duty owed to skier where risks were inherent); *Hammond v. Bd. of Educ.*, 100 Md. App. 60, 70, 639 A.2d 223, 228 (1994)(finding that school officials owed student no duty to warn of injury that may result from voluntary participation in high school football).

Specific to the intercollegiate student-athlete, in *Orr v. Brigham Young Univ.*, 960 F. Supp. 1522 (U.S. Dist Utah 1994), a college football player injured his back during practices and games while playing for BYU. In an attempt to impose liability upon that university for his injuries, that

plaintiff argued a "special relationship" existed by virtue of his student athlete status. Drawing upon much of the case law set forth *supra*, that court observed:

> The court finds nothing different about a student athlete's relationship with a university which would justify the conclusion that a student athlete is a custodial ward of the university while the non-athlete student is an emancipated adult. An athlete's choice to participate in a sport is not coerced. Voluntary association with a collegiate athletic team does not make the student less of "an autonomous adult or the institution more a caretaker." 960 F. Supp. 1522. *Affirmed on appeal, Orr v. Brigham Young Univ.,* 1997 U.S. App. LEXIS 6083 (10th Cir 1997).

Following the trend started by the Third Circuit in *Bradshaw*, *supra*, more than three decades ago, the *Orr* court ultimately rejected the claim that a "special relationship" existed between a university and its student athletes. *Accord, Howell v. Calvert,* 268 Kan. 698, 701-702 (2000) (no error in judge's refusal to instruct that college owed heightened duty of care to its student athletes).

Other courts have reached similar conclusions. In Connecticut, the courts have adopted a reckless or intentional conduct standard of care for co-participants in contact team sports. *See, Jaworski v. Kiernan,* 241 Conn. 399, 696 A.2d 332 (1997). In doing so, the Connecticut Supreme Court employed an eminently reasonable analysis weighing the following four factors:

> (1) The normal expectations of the sports in which the plaintiff and defendant were engaged; (2) the public policy of encouraging continued vigorous participation in recreational sporting activities while weighing the safety of the participants; (3) the avoidance of increased litigation; and (4) the decisions of other jurisdictions.

Another Connecticut case, and one that is closely analogous to the case at bar, found no heightened duty was owed to a basketball player who attempted to sue her coach after sustaining a concussion during a game. *See, Mercier v. Greenwich Academy, Inc.,* 2013 U.S. Dist. LEXIS 103950 (D.C. Conn. 2013). In particular, and following the precedent set by *Jaworski, supra,* the

Mercier court upheld the dismissal of the basketball player's case as to all but her allegations of reckless conduct. *Id.*

In *Karas v. Strevell*, 227 Ill. 2d 440, 884 N.E.2d 122, 318 Ill. Dec. 567 (Ill. 2008), another closely analogous case, a hockey player initiated a negligence action against referees and the league, among others, for injuries sustained during a game. *Id.* Exempting the league and others from negligence-based claims, the Supreme Court of Illinois reasoned that:

> coaching and officiating decisions involve subjective decision making that often occurs in the middle of a fast moving game. It is difficult to observe all the contact that takes place during an ice hockey game, and it is difficult to imagine activities more prone to second-guessing than coaching and officiating. Applying an ordinary negligence standard to these decisions would open the door to a surfeit of litigation and would impose an unfair burden on organizational defendants . . . *Id.* at 137.

In yet another persuasive case, California refused to apply an ordinary negligence standard in a lawsuit between a student athlete and her coach. *See, Kahn v. East Side Union High School Dist.*, 31 Cal. 4th 990, 4 Cal. Rptr. 3d 103, 75 P.3d 30 (Cal. 2003). Notwithstanding the fact that the student alleged her coach pushed her to dive into a pool despite her objections, lack of expertise, and fear of diving, the California Supreme Court noted that a coach's role "could be improperly chilled by too stringent a standard of potential legal liability." *Id.* As an Indiana Court observed:

> As to judicial policy, however, we are in agreement with our colleagues in the Court of Appeals and many of the courts of our fellow states that strong public policy considerations favor the encouragement of participation in athletic activities and the discouragement of excessive litigation of claims by persons who suffer injuries from participants' conduct. *Pfenning v. Lineman*, 947 N.E.2d 392, 403 (Indiana 2011).[6]

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[6] In *Pfenning*, the Indiana court rejected a "no duty" rule as being inconsistent with that state's comparative negligence framework. That rationale obviously would not apply in the District and it is noteworthy that the *Phenning* opinion cites to many additional jurisdictions which employ a "no duty" approach in sports injury cases.

Closer geographically to the District, its neighboring jurisdiction, Maryland, reached a similar conclusion in *Kelly v. McCarrick*, 155 Md. App. 82, 841 A.2d 869 (Md. App. 2004). There, a young girl injured her ankle during a softball game. Ultimately granting summary judgment based on that plaintiff's assumption of the risk, with respect to the duty owed the court observed that "[c]oaches and leagues are not insurers of athletic prowess; they cannot be expected to train players in a manner that eliminates all dangers created by misplay." *Id.* The Maryland Court of Special Appeals went on to state that:

> Sound public policy supports that conclusion. Much as they might wish otherwise, coaches cannot guarantee that their athletes will learn all the rules of the game, remember them in a game situation, and then properly execute the play according to those rules. It would unquestionably harm the sport to lay legal responsibility for an athlete's failure to understand a particular rule at the cleats of a coach who has offered that athlete time to learn the rule and to ask about it during practice and game situations. Indeed, if coaches and their sponsoring leagues can be held liable for a single player's unstated misunderstanding of rules governing a complex sport like softball, the type of instructional league that the Kelly's joined may quickly become a thing of the past. *Id.*

Notwithstanding this groundswell of persuasive authorities that go against imposing any duty in the context of student athletes, a few jurisdictions have found a special relationship between an institution of higher education and its student athletes. *See, e.g., Davidson v. University of N.C. at Chapel Hill*, 543 S.E.2d 920 (N.C. 2001); *Kleinknecht v. Gettysburg College*, 989 F.2d 1360, 1368 (3rd Cir. 1993). Those two cases are, however, limited and readily distinguishable.[7,8]

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[7] For example, in *Geiersbach v. Frieje,* 807 N.E. 2d 114 (Ind. 2004), which involved a college athlete's baseball injury, the Indiana Court of Appeals declined to follow the rational employed in *Davidson* and granted summary judgment in favor of the defendants. The "no duty" rule advocated in *Geiersbach* was subsequently disapproved of in *Pfenning, supra,* in favor of an intentional or reckless standard.

[8] Just two months ago, the Supreme Court of Pennsylvania determined that a lower court's reliance upon *Kleinknecht, supra* was erroneous because it applied "non-binding federal case law to impose what [the lower court] viewed as a new common law duty." *Feleccia v. Lackawanna College,* 215 A.3d 3, 12-13 (PA 2019). Other jurisdictions, like Connecticut and Indiana, also expressly considered and declined to follow *Kleinknecht. See, e.g., Mercier, supra; Geiersbach, supra.*

c. ***Duty Owed By The American University In The Case At Bar***

Given precedent in the District of Columbia established by *Breheny, supra,* and *Kelly, supra,* in Maryland, Defendant urges this Court to conclude that The American University owed no duty to Plaintiff in the case at bar. This would be consistent with the authorities set forth *supra* including, but not limited to *Pfenning* and the case law cited therein since the District is a contributory, not comparative, negligence jurisdiction. Given the undisputed express warning and voluntary undertaking by the Plaintiff, no other duty was owed to the Plaintiff in the case at bar such that summary judgment is proper in favor of American University.

Alternatively, if this Court were to employ a special relationship analysis, then consistent with jurisdictions like Connecticut, Illinois, Indiana, and others referenced above, this Defendant maintains that a heightened standard, i.e. reckless disregard and/or gross negligence, should be utilized. This standard would be consistent with the testimony of Plaintiff's own experts insofar as their opinions against American University were limited to making sure the Plaintiff was seen by a team physician, as was done in this case. *Exhibits 7-8.* More importantly, employing a gross negligence standard would serve a very important public policy consideration of minimizing the potential flood of litigation from the District's transient college student athlete population, who invariably sustain a myriad of injuries during their collegiate years. *Accord, Pfenning, supra.* Further still, as raised by other jurisdictions in the cases cited *supra*, failure to employ a heightened standard of negligence in the student-athlete context would force the District's colleges and universities to take ultra conservative precautions disparate from other similarly situated institutions of higher education throughout the country, invariably leading to a denigration in the competitiveness enjoyed by the District's exemplary collegiate athletic programs. Under such a

standard, the facts in the case at bar would also entitle American University to summary judgment as a matter of law.

B. *The Medical Malpractice Claim.*

This Court denied American University's Preliminary Motion to Dismiss Plaintiff's medical malpractice claim, because it felt "compelled to afford the plaintiff the opportunity to conduct discovery to determine whether the University and its field hockey athletic and medical staff qualify as healthcare providers." *ECF 36 at p. 49.* Having completed discovery, it is clear no medical services were rendered by American University.

a. Definition of Health Care Provider

District law expressly defines the term "Healthcare provider" within the context of a medical malpractice claim. *See,* D.C. Code, § 16-2801(2). Nowhere is a university, a coach, or an athletic trainer identified. Yet in 2014 – after the events in question -- D.C. Law 20-96 was passed which defined for the first time the "practice of athletic training," now codified at D.C. Code § 3-1201.02. This relatively new law defines, *inter alia,* the "Practice of athletic training" and an "athletic injury." *Id.* Taken together and in context, not only does an athletic trainer fall beyond the statutory definition of a health care provider under D.C. Code 16-2801(2) for the purpose of a medical malpractice claim, but legislation enacted ***after*** the events in question clearly define that the athletic trainers at American University can only treat an "athletic injury" under the direction of a physician; they cannot diagnose a concussion, much less treat one. Accordingly, the Plaintiff has failed to state a medical malpractice claim against American University.

b. D.C. law interprets "healthcare provider" to have its ordinary meaning.

Interpretations of the term "healthcare practitioner" in the District has not been expanded beyond the ordinary meaning of the term. For example, in a case against a local hospital and its

staff members this court found that "[w]ithout question, plaintiff's complaint alleges medical malpractice by healthcare providers operating in the District of Columbia." *Coleman v. Wash. Hosp. Ctr. Corp.*, 734 F. Supp. 2d 58 (D.D.C. 2010). Conversely, where the estate of an inmate alleged medical negligence claims against a private prison that hired a third-party vendor to provide medical care to inmates, this court found that even if the medical malpractice statute applied to wrongful death claims, a private prison "is not a healthcare provider within the meaning of the statute." *Smith v. Corr. Corp. of Am., Inc.*, 674 F. Supp. 2d 201, 209 (D.D.C. 2009). If a prison which is providing health care services to inmates is not considered a health care provider for purposes of the District's medical malpractice statute, then surely a college university who employs athletic trainers governed by a different set of rules and regulations would not be health care providers, either. Accordingly, Plaintiff has failed to state a medical negligence claim against American University.

c. Athletic Trainers are not healthcare providers in other legal contexts

Outside the medical malpractice context, the law continues to treat athletic trainers differently than traditional healthcare providers. For example, in *Nat'l Ath. Trainers' Ass'n v. United States HHS*, 455 F.3d 500 (5th Cir. Tex. 2006), the National Athletic Trainers' Association challenged HHS's Medicare Part B rule because it denied reimbursement for trainers' therapy services incident to physicians' services. The Court dismissed the case when it found that even if the athletic trainers had standing, there was no subject matter jurisdiction because physicians had administrative remedies available to them and an incentive to challenge. *Id.* Of note to the case at bar, the court explained that, unlike chiropractors, "the athletic trainers here are not service providers, therefore they cannot become assignees of the patients." *Id.* at 504. This portion of the opinion has been cited favorably by the District of Columbia Court of Appeals in *Colo. Heart Inst.*,

LLC v. Johnson, 609 F. Supp. 2d 30 (D.D.C. 2009), another case that dismissed a challenge to Medicare Part B for lack of subject matter jurisdiction. Just as athletic trainers do not qualify as medical providers under Medicare, they are not "healthcare providers" under the District's malpractice statute.

d. Maryland offers persuasive authority to give "healthcare provider" its ordinary meaning

Courts in Maryland have also interpreted the meaning of healthcare provider under that State's legal framework for medical malpractice claims. Similar to the D.C. statute's definition, Maryland Code, Courts and Judicial Proceedings Article § 3-2A-01 sets forth an expansive list of providers and individuals to whom those laws apply. Based on this definition, the Maryland Court of Appeals has determined that the Red Cross is not a "health care provider" and an injury related to "the organization's failure to adopt proper testing and screening procedures to eliminate the contamination of its blood donations" did not constitute medical malpractice. *Miles Lab., Inc., Cutter Lab. Div. v. Doe*, 315 Md. 704, 740-741 (Md. 1989). Similarly, an HMO is not included within the definition of health care provider. *Group Health Assoc. v. Blumenthal*, 295 Md. 104, 110 (Md. 1983). Nor would the Maryland Court of Appeals apply the definition of health care providers to regular employees at a doctor's office, noting:

> If we accept this analysis, a boy scout who renders medical aid to an injured person on a mountain trail has 'practiced medicine,' making him a physician. A waitress who performs the Heimlich maneuver on a choking restaurant patron has 'practiced medicine,' making her a physician." *Weidig v. Crites*, 323 Md. 408, 414-15 (Md. 1991).

In the case at bar, the University's athletic trainer did not have to employ any such emergency medical care but, rather, referred Plaintiff to a licensed physician. This does not render her a health care provider.

e. American University's Coaches and Trainers Are Not Health Care Providers

While nothing under the law in the District of Columbia would support the contention that a medical malpractice claim could be maintained against an athletic trainer or coach, persuasive case law exists for the exact opposite. For example, in *Mercier v. Greenwich Acad., Inc.*, 2013 U.S. Dist. LEXIS 103950 (D. Conn. July 25, 2013), a student athlete received a concussion during an athletic competition and alleged negligence against her coach and her school. The *Mercier* court dismissed that plaintiff's negligence claims, explaining that:

> holding coaches such as Tawney to a negligence standard of care would improperly chill the coach's role, which is to push athletes to perform in the context of a competition. Additionally, as the *Karas v. Strevell*, 884 N.E.2d 122, 137 (Ill. 2008)], court highlighted, coaching decisions involve split-second, subjective decisions. Because such decisions are particularly prone to second-guessing, permitting a negligence-based standard of care "would open the door to a surfeit of litigation and would impose an unfair burden on" coaches such as Tawney." *Id.*

The facts in the case at bar are even more compelling from American University's standpoint than in *Mercer*. In our case, the Plaintiff was seen by multiple health care providers – none of whom diagnosed a concussion. If trained health care providers could not diagnose Plaintiff's alleged injury, how could a coach or athletic trainer be expected to do so?

Plaintiff's lone legal authority in prior pleadings to advance a medical malpractice claim against an athletic coach and/or trainer was *Morris v. Adm'rs of the Tulane Educ. Fund*, 891 So. 2d 57 (2004). The court in *Morris,* however, relied on the Louisiana Medical Malpractice Act, which unlike the D.C. version, is broader than the District's statute. Specifically, a "health care provider" under the Louisiana statute broadly includes "any corporation whose business is conducted principally by health care providers, or an officer, employee, partner, member shareholder, or agent thereof acting in the course and scope of his employment." La. R.S. 40:1299.41(A). Ultimately, the *Morris* court could not determine whether the athletic trainers in

that case were qualified health care providers because the record did not have sufficient evidence as to whether Tulane was a "corporation whose business is conducted principally by healthcare providers." *Morris*, 891 So. 2d at 61. Obviously, that distinctive element of the Louisiana Medical Malpractice Act has no bearing in the case at bar.[9] Even then, the *Morris* court determined that under Louisiana law:

> [c]learly, the statute does not mandate that an athletic trainer be a physical therapist. Therefore, because an 'athletic trainer' is not included in the definition of 'health care provider' found in La. R. S. 40:1299.41(A)(1), we find, as a matter of law, that an athletic trainer is not automatically afforded the protections of the MMA." *Morris*, 891 So. 2d at 61.

Finally, this Court denied the University's Preliminary Motion to Dismiss because Plaintiff asserted that this Defendant's training staff negligently "medical tests and assessments." *ECF 36 at p. 49*. Plaintiff's own experts do not support any such claim. They are not, as Plaintiff originally implied, critical of any "medical tests" or "assessments" conducted by this Defendant. Instead, Plaintiff's own experts are of the opinion that the training staff's responsibility was to have the Plaintiff evaluated by a physician.[10] Their only criticism of the University's training staff is limited to a brief four day window when they did not withhold the Plaintiff from practice until she was seen by the team physician on October 5, 2011. *See, fn. 9.* This in no way amounts to the practice of health care under D.C. law. Accordingly, under both the facts and the law, American University is entitled to summary judgment as a matter of law on the Plaintiff's medical malpractice claim.

2. American University and Maryland Sports Medicine Center, David L. Higgins, M.D., and David L. Higgins, M.D., P.C. are entitled to Summary Judgment based on Waiver, Assumption of the Risk and Contributory Negligence.

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[9] Interestingly, in Louisiana "athletic trainers" are licensed and regulated by the Louisiana State Board of Medical Examiners. *See, Morris.* Even more telling, notwithstanding the fact that in Louisiana athletic trainers are licensed by the medical board, the *Morris* court ***still*** refused to automatically deem them health care providers.

[10] This Court denied Defendant's Motion to Dismiss the medical malpractice claim because Plaintiff claimed the training staff provided medical services. *ECF 36 at p. 49.* Plaintiff's experts clarified that the trainers were responsible for having Plaintiff examined by a doctor, not rendering medical services. *See, e.g., Exhibit 7 at pp. 44-47; 91; 123.*

A. Waiver / Release

Prior to the 2011 field hockey season, Plaintiff read and signed an "Acknowledgment of Risk" form whereby she expressly agreed to hold these Defendants harmless for any claims arising from her participation in field hockey. *See, generally,* **Exhibit 2.** In the District of Columbia exculpatory agreements between two parties are valid and enforceable as a complete defense to negligence claims. *Moore v. Waller,* 930 A.2d 176, 183 (D.C. 2007); *Wright v. Sony Pictures Entertainment, Inc.,* 394 F.Supp.2d 27, 34 (D.D.C. 2005) (applying District of Columbia law, "by voluntarily signing the Contestant Release Form, plaintiff waived his right to bring any claims for negligently caused personal injury"). However, an exculpatory clause which limits a party's liability for claims of gross negligence, recklessness, or intentional torts is unenforceable. *Carleton v. Winter,* 901 A.2d 174, 181-182 (D.C. 2006). Additionally, in order for an exculpatory or hold-harmless clause to be enforceable, it must be unambiguous such that it is "spelled out with such clarity that the intent to negate the usual consequences of tortious conduct is made plain." *Maiatico v. Hot Shoppes, Inc.,* 289 F.2d 349, 351 (D.C. Cir. 1961).

In *Moore v. Waller,* one of the leading cases on the validity of exculpatory clauses, the D.C. Court of Appeals enforced a gym membership agreement that contained a liability waiver which the plaintiff was required to sign before joining. *Moore,* 930 A.2d at 176. The plaintiff alleged that a kickboxing instructor, one of the gym's employees, asked him to hold a punching bag so that the instructor could demonstrate the proper kicking technique for the class. *Id. at* 177-178. The instructor proceeded to kick the bag five times as the plaintiff held it against his body, causing plaintiff to sustain torn ligaments and tendons from the trauma. *Id.* at 178. The Court affirmed the lower court's grant of summary judgment, holding that the exculpatory provision effectively precluded the plaintiff from bringing a claim for negligence against the gym or one of

its employee's. *Id. at* 177, 183. The court held that the language of the release was unambiguous, which stated that the plaintiff agreed "to assume any and all liabilities associated with the personal injury, which may result from or arise out of attendance at or use of the Club" and "released and discharged the Club… from any and all claims, damages, demands, rights or action or causes of action." *Id.* at 181.

Here, before participating in the 2011 field hockey season for American University, Plaintiff read and signed an "Acknowledgment of Risk" form dated July 25, 2011. The language of the waiver is virtually identical to the waiver in *Moore*, as it stated:

> I understand that participation in intercollegiate athletics involves a risk of injury which may range in severity from minor to catastrophic, including but not limited to serious permanent paralysis, bone/joint or other bodily injury, **concussions**, and other chronic disabling conditions and even death.
>
> …
>
> I (including my parents, legal guardians, and legal representatives) hereby **agree to indemnify, defend, and hold harmless the University and its employees**, officers, agents from any claims, demands, or suites for damages which may arise from my participation in the University's Intercollegiate Athletic Program; or from any treatment, medical, or otherwise provided to me by the University's Sports Medicine Staff. Further, **I absolve, indemnify, defend and hold harmless American University** from any breach of those presentations.

Exhibit 2 (emphasis added). At Plaintiff's deposition, she testified that she remembers filling out the release before the start of the season and at no point has Plaintiff alleged that she did not understand the language in the form. *See, Exhibit 3* at 39:10-39:24.

It is also noteworthy that the language of the Acknowledgment of Risk includes not only "damages which arise from my participation in the University's Intercollegiate Athletic Program," but also "from any treatment, medical, or otherwise provided to me by the University's Sports Medicine Staff" as well. *See, Exhibit 2.* In *Jaffe v. Pallotta Teamworks*, 276 F. Supp. 2d 102 (D.D.C. 2003), a plaintiff signed a waiver prior to participating in a biking event. *Id.* at 104.

During the race, that plaintiff presented to one of the event's medical tents with complaints of dizziness and nausea. *Id.* Under the care of the event's medical team, the plaintiff's condition deteriorated and she passed away secondary to brain hypoxia. *Id.* The plaintiff's estate commenced an action against the event for negligently equipping the medical tents, as well as negligently diagnosing, monitoring, and treating the plaintiff. *Id.* The court upheld the waiver and rejected the argument that it was unenforceable because it pertained to the rendering of health care, which is a public interest. *Id.* at 109. Specifically, the court held that the waiver was signed in exchanged for participation in the biking event, and not signed in exchange for the rendering of health care. *Id.* The mere fact that the waiver included a release of liability for medical negligence claims was insufficient to invalidate it on the grounds that it violates public interest. *Id. Jaffe* was ultimately reversed on a choice of law analysis in which the United States Court of Appeals for the District of Columbia determined that Virginia law, not the District's law, applied, but the District Court's analysis of D.C. law on exculpatory agreements was not reversed. *See, Jaffe v. Pallotta TeamWorks*, 374 F.3d 1223, 362 U.S.App.D.C. 398 (2004).

Outside of the District of Columbia, Pennsylvania just recently applied a similar exculpatory contract to preclude a student athlete's negligence claim against a junior college. *See, Feleccia v. Lackawanna College,* 215 A.3d 3 (PA 2019). In that case, Pennsylvania's highest court concluded that the college through its affirmative conduct assumed a duty to provide certified athletic trainers at its sporting events. *Feleccia, 215 A.3d at 16.* Regarding the issue of waiver, notwithstanding the fact that under Pennsylvania law "exculpatory contracts are generally disfavored, and subject to close scrutiny," the *Feleccia* court granted summary judgment in favor of the college on plaintiff's negligence claims. *Feleccia, 215 A.3d at 17.* Given the law in the District set forth above, the *Feleccia* case is virtually indistinguishable from the case at bar.

Precedent exists elsewhere, as well. For example, in *Nat'l & Internat. Bhd. of St. Racers v. Superior Court*, 215 Cal. App. 3d 934, 264 Cal. Rptr. 44 (1989), a racecar driver was injured while being extricated from his vehicle after crashing it during a race. *Id.* The language of an exculpatory agreement signed by the driver released the race organizer "from any and all claims and liability arising out of… ordinary negligence." *Id.* at 936. That plaintiff argued that because his negligence claim was not for a risk inherent in racing, but rather for the lack of proper training and extraction equipment of the rescue personnel, the release did not apply. *Id.* at 936-937. The Court dismissed plaintiff's claim on the grounds that the "blanket release of responsibility on the part of the race organizer and landowner was all-encompassing." *Id.* at 937.

In sum, Plaintiff signed a broad exculpatory agreement which is clearly enforceable under the law of the District of Columbia. Because the Acknowledgment of Risk form signed by Plaintiff applies to injuries arising from inherent risks of the sport, such as concussions, as well as the subsequent treatment of such injuries, these Defendants are entitled to summary judgment as a matter of law.

B. Assumption Of The Risk.

Plaintiff assumed the risk of sustaining a concussion with permanent, post-concussion symptoms by voluntarily participating in collegiate field hockey. This is undisputed because she had (1) actual knowledge and comprehension of the danger of head injuries in the sport of field hockey; and (2) she willingly exposed herself to such danger by voluntarily participating in the sport. As such, Plaintiff's claims are barred by her assumption of the risk.

In the District of Columbia, the doctrine of assumption of the risk is a well-settled affirmative defense in negligence actions that serves as a complete bar to a plaintiff's recovery. *Morrison v. MacNamara*, 407 A.2d 555, 566 (D.C. 1979). The principle elements of the defense

are actual knowledge and comprehension of a danger caused by the defendant's negligence and [2] the plaintiff's voluntary exposure to that known danger. *Morrison,* 407 A.2d at 567. Assumption of the risk serves as a complete bar to recovery because "the plaintiff has consciously relieved the defendant of any duty which he otherwise owed the plaintiff." *Sinai v. Polinger Co.*, 498 A.2d 520, 524 (D.C. 1985).

a. *Plaintiff Had Actual Knowledge Of The Risk Of Concussions*

Before joining American Women's Field Hockey team, Plaintiff had actual knowledge and comprehension of the risk of sustaining a concussion. Her actual knowledge and comprehension is evidenced by her many years of playing field hockey at various competitive levels including college and junior Olympics. *See, Exhibit 3* at 30:14-30:20; 36:11-36-22, 37:21-38-7. Additionally, Plaintiff had express notice of the risk of concussion having read and signed a Concussion Statement and Acknowledgement of Risk form. *See, Exhibits 1 and 2.* She even conceded at deposition she was aware of the risk of concussion associated with playing field hockey, testifying that "I think I understood that with any physical activity there's a chance to get injured to any part of your body." *Exhibit 3* at 36:11-36:17. For good measure, she even knew the University administered a preliminary concussion test before beginning the field hockey season in order to obtain a baseline. *Id.* at 253:16-253:21.

In short, the Plaintiff had actual knowledge of the risk of concussion when playing field hockey. She further acknowledged that risk in writing and then proceeded to voluntarily assume that risk when she played field hockey.

b. *Plaintiff's Voluntarily Exposure To The Danger Of Concussions*

The second element of assumption of the risk is that the plaintiff must freely and voluntarily incur the known risk. *District of Columbia v. Mitchell*, 533 A.2d 629, 639 (D.C. 1987). Freely

and voluntarily incurring the risk can be "express, as in the case of a contractual absolution from liability, or implied by conduct." *Martin v. George Hyman Constr. Co.*, 395 A.2d 63, 71 (D.C. 1978). Express assumption of the risk is when Plaintiff consents to incur the risk through a contract-type agreement. *Restatement (Second) of Torts §496B cmt. A.* (Am. Law Inst. 1965). Assumption of the risk can be implied when Plaintiff, after being made aware of the risk, "deliberately chooses to encounter that risk." *Morrison v. MacNamara*, 407 A.2d 555, 566 (D.C. 1979).

Here the Plaintiff both expressly and impliedly assumed the risk of sustaining a concussion. She expressly assumed the risk by signing the Acknowledgment of Risk form and the Concussion Statement before participating in the 2011 field hockey season. In addition, Plaintiff also assumed the risk impliedly by voluntarily choosing to participate in the sport of field hockey at the college level. Under District of Columbia law, "it is generally held that a participant in an extracurricular athletic activity assumes the risk of injuries associated with or incidental to that activity." *Breheny v. Catholic University of America,* 1989 U.S. Dist. LEXIS 14029, 5, 1989 WL 1124134. In *Breheny*, Plaintiff was a college student who fractured her ankle during an intramural touch-football game sponsored by her University. *Id.* at 1. The Defendant moved for summary judgment, arguing that Plaintiff voluntarily assumed the risk of injury by participating in the sport. *Id.* The Court granted Defendant's motion, ruling that Plaintiff had sufficient knowledge of the risk of slipping on a wet field, and voluntarily encountered such risk by deciding to participate in the game of touch-football. The Court went as far as stating that the "parties have cited no cases under District of Columbia law in which a sports participant sought to recover damages in a negligence action such as this one, and the Court's own research has revealed none." *Id.* at 6. *Accord, Benitez v. New York City Bd. Of Educ.,* 72 N.Y.2d 650, 541 N.E.d 29, 543 N.Y.S.2d 29 (N.Y.

1989)(rejecting Plaintiff's claim that he did not voluntarily assume the risk of breaking his neck during a football game because of the "indirect compulsion" of participating in order to maintain his athletic standing and scholarship opportunities.)

In sum, having met both elements of an assumption of the risk defense these Defendants are entitled to summary judgment on Plaintiff's assumption of the risk as a matter of law.

C. Contributory Negligence

Plaintiff's separate and independent contributory negligence also operates as an alternative bar to any recovery by the Plaintiff in the case at bar. Plaintiff had a duty to report concussion-like symptoms to the coaching and/or training staff at American University, yet she negligently failed to do so until October 2nd, despite testifying that she felt "a little bit out of it" on September 23rd, when the alleged concussion occurred. *See, Exhibit 3* at 44:18-44:22; 51:18-53:2. Plaintiff's expert, Dr. Cantu, testified that the critical time for cognitive and physical rest after a severe concussion is the first seven days after sustaining the concussion, "[A]nd if you don't have cognitive and physical rest in the early time period, you have a greater chance to provoke symptoms to have a more prolonged recovery." *See, Exhibit 7* at 52:6-52:22. That is because, in his opinion, the first seven days post-concussion is a critical period of metabolic crisis, requiring both cognitive and physical rest. *Id.* at 52:6-52:22. Therefore, if one were to assume that the Plaintiff's initial injury caused by the concussion was exacerbated by a delay in diagnosing a concussion, then by waiting nine (9) days to report her symptoms, Plaintiff's own negligence contributed to her alleged prolonged concussion symptoms.

In the District of Columbia, "the plaintiff is barred from recovery if his negligence was a substantial factor in causing his injury, even if the defendant was also negligent, as long as the plaintiff's negligence contributed 'in some degree' to his injury." *Sinai v. Polinger Co., et al.*, 498

A.2d 520, 528 (D.C. 1985). The defense of contributory negligence applies even if a defendant was deemed negligent because it "precludes recovery to a plaintiff who, in effect, failed to take due care for his own well-being." *Martin v. George Hyman Const. Co.*, 395 A.2d 63, 69 (D.C. 1978). Assumption of the risk and contributory negligence are two distinct defenses in this jurisdiction, with the main difference being "inquiry into assumption of the risk focuses on what the plaintiff in fact knew, while the defense of contributory negligence requires a determination of what the plaintiff should have known." *Morrison v. MacNamara*, 407 A.2d 555, 566 (D.C. 1979).

Consistent with Plaintiff's affirmative obligations to timely report signs and symptoms of a concussion as set forth in her signed Concussion Statement and Acknowledgement of Risk form discussed *supra,* American University's standard of care expert, Tory Lindley, explained that Plaintiff had a duty to timely report symptoms of her concussion. *See, Report of Defendant's Expert Tory Lindley at pg. 3, attached hereto as* **Exhibit 9.** Specifically, Mr. Lindley opined:

> As noted in the research cited above, as well as in the NATA Position Statement, appropriate management of sport-related concussion begins with timely and truthful reporting of clinical symptoms; "[i]t is equally important for the athlete to understand the signs and symptoms of a concussion as well as the negative consequences (eg second-impact syndrome and predisposition to future concussions) of not reporting a concussive injury."

Id. The undisputed facts in the case at bar, according to the Plaintiff herself, are that she first remembers feeling the symptoms of the concussion on September 23, 2011, during the game against Richmond, the same day she allegedly sustained the head injury. *See, Exhibit 3* at 44:18-44:22. Specifically, she remembers "being a little off, a little bit out of it," but did not bring complaints to the training staff. *Id.* Plaintiff testified that during the next game against Boston College on September 25, 2011, she had vision problems, problems with her concentration, and experienced fatigue. *Id.* at 49:13-49:23. Despite having an immediate onset of symptoms following the purported impact to her head on September 23, 2011, Plaintiff did not report these

symptoms until nine (9) days later, on October 2, 2011. *Id.* at 51:18-53:2. Because she undeniably had a duty to timely report her symptoms of a concussion, she failed to do so, and her own expert opined that the delay was during a critical time period for rest and recovery, as a matter of law the Plaintiff's claims are barred by her own contributory negligence.

3. American University, Maryland Sports Medicine Center, David L. Higgins, M.D., and David L. Higgins, M.D., P.C. are Entitled to Summary Judgment due to Lack of Medical Causation Testimony.[11]

Assuming arguendo Plaintiff's claims somehow survive despite the arguments set forth above, Plaintiff still would not be able to recover because her experts cannot advance a cogent causation theory. Originally, the defense believed Dr. Cantu and Dr. Vollmar were going to somehow opine that had Defendants diagnosed a concussion and withheld Plaintiff from play, she would not have developed permanent post-concussion syndrome. *See, Plaintiff's Rule 26(A)(2) Disclosures of Dr. Cantu and Dr. Vollmar.* At deposition, however, Dr. Vollmar rescinded any such causation opinion and testified that even if Plaintiff had promptly reported her symptoms and American University held her out from further participating in field hockey, her conditions may still be as severe as she currently alleges "because once the hit was done, the damage was done." *See, Exhibit 8* at 117:11-118:12. When specifically asked whether Plaintiff would still have developed post-concussion syndrome had she never played field hockey again after sustaining the initial alleged hit on September 23, 2011, he responded "[I]t's impossible to answer that question from a clinical standpoint." *Id.* at 120:17 – 121:6.

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[11] These Defendants are filing a Joint Motion for Summary Judgment pursuant to this Court's September 24, 2019 Order directing them to do same. However, the argument as to legal causation is slightly different as to these Defendants. Insofar as American University is concerned, its employees are only alleged to have been negligent during a very small window of time, from October 2, 2011 to October 5, 2011. *See, e.g. Exhibit 7 at pp. 44-47; 91; 123.* Because the Plaintiff only engaged in two limited field hockey practices during that window of time, Plaintiff's causation claims are particularly tenuous as to American University.

Plaintiff's other medical expert, Dr. Cantu, described Plaintiff's September 23rd concussion as "severe" and identified the critical rest period following a severe concussion to be as long as one week. *See, Exhibit 7* at 51:10-51:17; 52:6-52:22. When asked whether rest in the first week after a concussion increases the chance of avoiding a permanent post-concussion injury, he nonetheless candidly responded "I don't think we know the answer to that." *Id.* at 56:11-58:1. He further acknowledged that while the risk of playing athletics with a concussion is what is referred to in sports as "second-hit syndrome," there is no evidence this Plaintiff sustained a second hit and/or direct injury during the remainder of the 2011 field hockey season. *Id.* at 62:23-63:23. Ultimately, and most importantly, Dr. Cantu was unable to opine that, had the Plaintiff rested during the three day window of October 2, 2011 and October 5, 2011, there would have been any difference in her ultimate outcome. *Id.* at 61:18-62:19. In fact, Dr. Cantu could not pinpoint any date by which Plaintiff needed to stop playing or practicing so as to prevent her alleged injuries. *Id.* at 79:25-81:5, 60:4-62:19.

Also relevant for the purposes of this Motion, Dr. Cantu and Dr. Vollmar both admitted at deposition that there is no study or peer-reviewed publication to support a theory of causation that three (3) or more days of physical activity, at a point in time nine (9) days removed from the concussion, or any time thereafter, causes permanent post-concussion syndrome. *See, Exhibit 7* at 56:14–57:4; *See also, Exhibit 8* at 119:4-119:19. Of course, any such claim would be belied by common sense as well as the best available medical literature on the subject of concussions.

a. Plaintiff's Experts' Fail To Satisfy The Daubert Standard Of Reliability

Under Rule 702, an expert may testify only when "scientific, technical, or other specialized knowledge will assist the trier of fact." *Fed. R. Evid. 702.* In interpreting and applying Rule 702, the District of Columbia follows the *Daubert* standard, which "involves a two-prong analysis that

centers on evidentiary reliability and relevancy." *Ambrosini v. Labarraque,* 101 F.3d 129, 133 (D.C. Cir. 1996). An expert's opinion is considered reliable if the "reasoning or methodology underlying the testimony is scientifically valid." *Daubert v. Merrell Dow Pharm., Inc.,* 509 U.S. 579, 592-593 (1993). An expert's opinion is considered relevant if "that reasoning or methodology properly can be applied to the facts in issue." *Id.*

Due to the influence that expert testimony may have over a jury, the District Court judge must act as a gatekeeper to prevent the admission of unreliable expert testimony. *Daubert v. Merrell Dow Pharm., Inc.,* 509 U.S. 579, 600 (1993). The proponent of the expert testimony bears the burden of establishing that the expert's opinions are both reliable and relevant. *Bazarian Int'l Fin. Assocs., LLC v. Desarrollos Aerohotelco, C.A.,* 315 F. Supp. 3d 101, 118 (D.D.C. 2018). Federal courts must apply the *Daubert* standard of reliability to an expert's opinion on the probable cause of a medical condition. *See, e.g., Raynor v. Merrell Pharm.,* 104 F.3d 1371 (D.C.Cir. 1997); *Ambrosini,* 101 F.3d 129.

In order for an expert opinion on causation to be reliable, and thus admissible, it must be based on "scientific knowledge." *Ambrosini*, 101 F.3d at 135-136. This requires the court to determine whether the scientific methodology underlying an expert's opinion is grounded in "procedures of science" and "supported by appropriate validation." *Daubert*, 509 U.S. at 590. (instructing courts to focus exclusively on "principles and methodology, not on the conclusions that they generate"). The District of Columbia Circuit lists a number of factors to consider in determining whether an expert's methodology at arriving at an opinion is reliable, including:

(1) Tests and Studies: "whether the theory or technique can be and has been tested";

(2) Peer Review: "whether the theory or technique has been subjected to peer review and publication";

(3) Error Rate: "the method's known or potential rate of error"; and

(4) General Acceptance: "whether the theory or technique finds general acceptance in the relevant scientific community"

Ambrosini, 101 F.3d at 134. (internal citations omitted). The court notes that the inquiry must be "flexible" and that "none of the factors discussed is necessarily applicable in every case or dispositive; nor are the four factors exhaustive." *Id.*

Plaintiff's experts fail to satisfy the first "reliability" factor: "(1) whether the theory or technique can be and has been tested." *Id.* The Court in *Daubert* highlighted the importance of this first reliability factor, noting that "scientific methodology today is based on ***generating hypotheses and testing them*** to see if they can be falsified; indeed, this methodology is what distinguishes science from other fields of human inquiry." *Daubert*, 509 U.S. at 593(emphasis added); *In re Accutane Products Liability,* 511 F.Supp. 2d 1288, 1296 (M.D. Fla. 2007)(finding that without objective validation and verification, an expert's theory is just an educated guess.). As one federal court stated, "given the general inability of a physician to make accurate predictions of causation without at least some reference to epidemiological studies," an opinion not premised on a study or test "amounts to nothing more than speculation." *Heyman v. United States,* 506 F.Supp. 1145, 1149 (S.D. Fla. 1981); *Boyles v. American Cyanamid Co.,* 796 F.Supp. 704, 709 (E.D.N.Y. 1992) (excluding expert medical causation testimony compelled by the nonexistence of any medical or scientific study which supports their conclusions); *Porter v. Whitehall Labs., Inc.,* 791 F.Supp 1335, 1339 (S.D. Ind. 1992) (excluding expert causation testimony due to the complete absence of any scientific or epidemiological tests or studies).

In the case at bar, neither Dr. Cantu nor Dr. Vollmar could cite to any test, either conducted by themselves or someone else in the science field, to support the hypothesis that failure to rest more than a week after a concussion causes post-concussion syndrome. *See, Exhibit 7* at 56:14 – 57:4, *See Exhibit 8* at 119:4 – 119:19. Of note, Plaintiff's experts not only deny the existence of a

study that supports an opinion that failure to rest more than a week after a concussion causes post-concussion syndrome, they also go as far as denying the existence of any study that shows failure to rest "at day one of a concussion" causes post-concussion syndrome.

The lack of reliability underlying Plaintiff's experts' causation opinions becomes even more apparent when assessing the second factor: "(2) whether the theory or technique has been subjected to peer review and publication." *Ambrosini*, 101 F.3d at 134. Courts have expressed that the publication and peer review of expert opinions ensures reliability because "submission to the scrutiny of the scientific community is a component of good science." *Lakie v. Beecham, et al.*, 965 F.Supp 49, 56 (D.D.C. 1997). Peer review, which is the process by which a scientist submits his work, research, or theories to other experts in the same field for critiquing, is viewed by courts to be a cornerstone of reliability. *Wheat v. Pfizer, Inc.*, 31 F.3d 340, 343 (5th Cir. 1994) (excluding expert's opinion on drug interactions because the theory had not been studied and "[n]either had it been subjected to peer review and publication, which *Daubert* also identifies as key").

In applying *Daubert,* this Court has excluded expert opinions as unreliable when they were not supported by scientific studies, nor subjected to peer-review. *United States v. Stagliano,* 729 F. Supp. 2d 222 (D.D.C. 2010). In *Stagliano,* the Defendant offered a clinical psychologist as an expert to opine that a particular method of treatment could be used to treat his condition. The clinical psychologist admitted that he was unaware of any study that supported the effectiveness of this treatment, and that he himself had never submitted any publication of his theory to peer review. *Id.* at 228. In excluding the expert's opinion, the court found that "because Dr. Sank's method of treatment had been neither tested nor peer reviewed through publication by him or

others,… I concluded that the methodological basis for his appoint testimony was not sufficiently reliable." *Id.*

Here, neither Dr. Cantu nor Dr. Vollmar know of any study or test to support an opinion that participation in physical activity more than a nine (9) days after sustaining a concussion causes post-concussion syndrome. Furthermore, the experts have not submitted their theory for peer review, nor do they rely on any other peer reviewed publication to support their opinions. In accordance with the ruling in *Stagliano,* because these experts proffer an opinion unsupported by studies or peer reviewed publications, the opinions are unreliable and should be excluded.

Applying factors three (3) *Rate of Error,* and four (4) *General Acceptance* of the reliability analysis to Plaintiff's experts' opinions reveal further deficiencies in their methodology. *Ambrosini,* 101 F.3d at 134. (internal citations omitted). Here, it is impossible for Defendants to calculate the error rate of Dr. Cantu and Dr Vollmar's medical causation opinions because they are not based on any studies or testing. *Cavallo v. Star Enterprise,* 100 F.2d 1150, 1158 (4th Cir. 1996). Additionally, their opinions cannot be said to have "general acceptance" in their field as not one study, test, or publication, peer reviewed or not, supports their theory.

In short, because the medical causation opinions of Dr. Cantu and Dr. Vollmar do not satisfy any of the four reliability factors, their opinions must be excluded under the *Daubert* standard.

b. *Plaintiff's Medical Causation Theory Fails To Account For Alternatives*

Plaintiff's experts cannot opine that despite having sustained a concussion on September 23rd and continuing to play with it for nine (9) days before notifying the American University training staff, it was something done thereafter which caused her condition to become permanent. Plaintiff's experts acknowledge a number of different causes of post-concussion syndrome, including biological factors, genetic pre-disposition, pre-existing health conditions, gender, and

social influences. Yet, both experts also admitted to being unaware of Plaintiff's pre-concussion medical history.

In the 2000 Amendments to Rule 702, the Advisory Committee affirmed support for the reliability factors laid out by *Daubert* and provided additional factors for the court to assess in determining reliability of expert testimony. Fed. R. Evid. 702 (2000 Advisory Committee Notes). One of those factors, highly relevant to medical causation testimony, is as follows:

> Alternative explanations: "Whether the expert has adequately accounted for obvious alternative explanations"

Id. An expert is not required to address each possible alternative explanation, but must address why "other recognized causes, alone, are not responsible for the disease in a particular plaintiff. *Daniels v. Pfizer (In re Lipitor (Atorvastatin Calcium) Mktg., Sales Practices & Prods. Liab. Litig.)*, 185 F. Supp. 3d 786, 800 (D.S.C. 2016). When there is an obvious, plausible alternative cause of Plaintiff's injury, "and the doctor offers no explanation for why he or she has concluded that was not the sole cause, that doctor's methodology is unreliable." *Heller v. Shaw Indus., Inc.*, 167 F.3d 146, 156 (3d Cir. 1999)(internal citations omitted).

The facts at hand are similar to those in a recent federal district court case whereby the Court struck Plaintiff's expert's medical causation opinion for lacking reliability. *Smith v. Terumo Cardiovascular Sys. Corp.* No. 2:12-cv-00998-DN, 2017 U.S. Dist. LEXIS 108205 (D. Utah July 12, 2017). In *Smith*, Plaintiff's decedent passed away of a heart attack, eleven months after undergoing open-heart surgery during which one of the heart machines stopped working for a period of ten minutes. *Id.* at 3. In support of Plaintiff's claims against the hospital and machine manufacturer, Plaintiff retained a cardiologist as a medical causation expert who opined that the brief ten minutes when the machine was not functioning properly is what caused Plaintiff's heart attack. *Id.* at 8. The Court excluded the expert's testimony as unreliable on the grounds that "he

fail[ed] to fully account for obvious alternative explanations of the cause" of Plaintiff's death, including Plaintiff's underlying coronary artery disease. *Id.* at 11, 16. Additionally, the Court found that although the expert's report opined that a complication-free surgery would have prevented his death, his deposition testimony contradicted this as he stated he "couldn't say with certainty that the event that happened during surgery caused his myocardial infarction." *Id.* at 17.

Here, similar to the underlying cardiovascular disease exhibited by the Plaintiff in *Smith,* the most obvious cause for Plaintiff's alleged permanent post-concussion syndrome is the September 23rd concussion itself, and the nine (9) subsequent days where Plaintiff continued practicing and playing in games before American's alleged negligence began on October 2nd. In opining as to medical caution in this case, Dr. Cantu and Dr. Vollmar never provide an explanation as to why the hit itself and the subsequent physical activity up until October 2nd was not the sole cause of the injury. In fact, at many points, the experts actually acknowledged that the hit and subsequent nine (9) days could very well be what caused Plaintiff's alleged permanent post-concussion syndrome. *See, e.g. Exhibit 8* at 117:11-118:2. When Dr. Vollmar was asked to give a date at which, had Plaintiff been held out from play, she would not have developed post-concussion syndrome, he responded "[a]gain, I cannot give that as an exact." *Id.* at 118:7-118:18. Dr. Vollmar further testified that from a clinical standpoint, "it's impossible to answer" whether Plaintiff would have developed post-concussion syndrome had she properly been held out of play immediately following the concussion. *Id.* at 120:17-121:6. *See, McClain v. Metabolife Int'l, Inc.,* 401 F.3d 1233, 1243 (11th Cir. 2005)(finding the methodology of medical causation expert to be unreliable, in part, for failing to consider the likelihood of injury regardless of treatment).

Dr. Cantu testified in a similar manner, stating that there is more than one explanation for why people develop permanent post-concussion syndrome, one of them being "those individuals

have structural brain damage that precludes – enough of it that precludes a complete recovery." *See, Exhibit 8* at 51:10-51:17. Being that Dr. Cantu characterized the Plaintiff's concussion on September 23rd to be "severe," it is more than possible that the "structural brain damage" from the hit itself is what is precluding Plaintiff from making a complete recovery. *Id.* at 84:2-84:6. Therefore, it remains unclear why Dr. Cantu does not consider the September 23rd blow to the head and nine (9) days thereafter to be the sole cause of Plaintiff's alleged permanent injury, rather than three (3) days of physical activity that she engaged in from October 2nd through October 5th, or any physical activity she engaged in thereafter.

Additionally, the Court should also exclude Plaintiff's experts' causation opinions as unreliable because Dr. Cantu identified the critical time for rest after a concussion as being 48 hours for minor concussions, and up to a week for severe concussions. *See, Exhibit 8* at 52:6-52:22. He reiterated this importance of the first week of rest, testifying that patients who exert themselves physically, within the first week after a concussion, can be expected to have a slower recovery. *Id.* at 55:24-56:10. Under this logic, the critical rest period after Plaintiff "severe" concussion, as described by Dr. Cantu, was one week, until September 30th. According to Dr. Cantu's testimony, it is within this timeframe that Plaintiff's failure to rest caused her post-concussion syndrome. *Id.* However, this critical rest period does not overlap with the (3) days of American's alleged negligence which began on October 2nd, when they were notified of Plaintiff's complaint and ended October 5th, when she was seen by the team physician.

c. *Plaintiff's Experts' Ipse Dixit Testimony*

If an expert proffers an opinion which has not been published, or peer reviewed, then "the experts must explain precisely how they went about reaching their conclusions and point to some objective source—a learned treatise, the policy statement of a professional association, a published article in a reputable scientific journal or the like—to show that he has followed the scientific

method, as it is practiced by (at least) a recognized minority of scientists in his field." *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 43 F.3d 1311, 1318-19 (9th Cir. 1995). An expert must do more than merely assure an opinion is based on reliable scientific methodology. *Moore v. Ashland Chem. Inc.*, 151 F.3d 269, 276 (5th Cir. 1998). The court "requires some objective, independent validation of the expert's methodology." *Id.* Because courts require objective, independent validation of the expert's methodology, "nothing requires a district court to admit opinion evidence that is connected to existing data only by the *ipse dixit* of the expert." *Parsi v. Daioleslam*, 852 F. Supp.2d 82, 86 (D.D.C. 2012)(quoting *Daubert*, 118 S.Ct. 512).

Courts in the District of Columbia have been staunch in rejecting expert opinions as unreliable when based solely on the *ipse dixit* of the expert. *Campbell v. AMTRAK*, 311 F.Supp.3d 281 (D.D.C. 2018); *Cooper v. Marten Transport, Ltd.*, 539 F. App'x 963, 966 (11th Cir. 2013)(defining *ipse dixit* as "tak[ing] the expert's word for it."). When experts proffer medical causation absent reference to supporting studies or testing, reliance on the mere *ipse dixit* of the expert is insufficient to establish reliability. *Meister v. Med. Eng'g Corp.*, 347 U.S. App. D.C. 361, 267 F.3d 1123, 1126 (2001); *Perkins v. Hansen*, 79 A.3d 342, 345 (D.C. 2013)(Finding that an expert must "have a reliable basis for [his] theory steeped in fact or adequate data, as opposed to offering a mere guess or conjecture"). Proffering nothing other "than credentials and a subjective opinion" makes an opinion unreliable as it relies on nothing more than the *ipse dixit* of the expert. *Russell v. Call/D, LLC*, 122 A.3d 860, 867 (D.C. 2015).

If the court does not disqualify Dr. Cantu and Dr. Vollmar's opinions for lacking supporting studies and peer-reviewed publications, or for not considering more obvious alternatives as to causation, they should nonetheless be excluded for relying on the mere *ipse dixit* of the experts. After review of Plaintiff's experts' deposition testimony, it is apparent that Plaintiff

expects the parties to accept their opinions as reliable based on the experts' qualifications, experience, and knowledge in the field, and not based on any objective, scientific grounds. It is clear because throughout their testimony, neither Dr. Cantu nor Dr. Vollmar point to any objective source upon which they rely to form their opinions that American University's alleged negligence from October 2nd until October 5th or any alleged negligence thereafter caused Plaintiff's permanent post-concussion syndrome. The experts do not point to any objective source that they relied upon in formulating their opinions. They do not assert that their causation opinions are based on any treatise, published article, or scientific journal. Although the credentials and qualifications of Plaintiff's experts may appear acceptable, alone, credentials are insufficient to establish reliability of their opinions as to medical causation in this case.

d. *Without Causation, Defendants Are Entitled To Summary Judgment*

It is axiomatic that "[t]he elements of a negligence claim are (1) a duty of care; (2) a breach of that duty; and (3) damage to the plaintiff proximately caused by the breach of duty." *Meehan v. U.S. Office Prods. Co.* (*In re U.S. Office Prods. Co. Sec. Litig.*), 251 F. Supp. 2d 77, 98 (D.D.C. 2003), citing *District of Columbia v. Cooper*, 483 A.2d 317, 321 (D.C. 1984). Applying District of Columbia law, in order to establish the causation element, the plaintiff must establish, by a preponderance of the evidence, that the asserted negligence was a "substantial factor" in causing the injury. *Daniels v. Hadley Mem'l Hosp.*, 566 F.2d 749, 757 (D.C.Cir. 1977). The court requires that plaintiff present expert testimony to establish causation "[i]n cases presenting medically complicated questions due to multiple and/or preexisting causes, or questions as to the permanence of an injury." *Williams v. Patterson*, 681 A.2d 1147, 1150–1151 (D.C. 1996).

Because Plaintiff's experts' medical causation opinions must be excluded under *Daubert* for a lack of reliability as set forth *supra*, Plaintiff has insufficient evidence of causation to survive a summary judgment motion. Summary judgment is properly granted when "the pleadings,

depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." *Fed. R. Civ. P. 56(c)*. Absent expert testimony as to the element of causation, Plaintiff is unable to establish a negligence prima facie case, and therefore, summary judgment is appropriate. *Testerman v. Riddell, Inc.*, 161 Fed. Appx. 286, 290 (4th Cir. 2006); *See also, Martin v. Omni Hotels Mgmt. Corp.*, 321 F.R.D. 35, 40-41 (D.D.C. 2017)(granting of summary judgment is proper when Plaintiff's expert does not "explain the scientific data on which his conclusion was based").

The facts of our case are factually analogous to the facts of a recent case decided by a neighboring federal court. *Testerman v. Riddell, Inc.*, 161 Fed. Appx. 286 (4th Cir. 2006). In *Testerman,* the Plaintiff sued a sports equipment manufacturer for negligence after being injured while wearing Defendant's shoulder pads. *Id.* at 288. The district court excluded Plaintiff's expert's medical causation opinion as unreliable under Rule 702 because the expert failed to consider alternative explanations. *Id.* at 289. Because the Plaintiff could not prove his negligence claim without expert testimony as to causation, the district court granted Defendant's motion for summary judgment. *Id.* at 290. The Fourth Circuit affirmed the summary judgment ruling, "because well-established Virginia tort law supports the district court's conclusion that Testerman could not prevail at trial without offering expert testimony on causation." *Id.*

Similarly, well-established tort law in the District of Columbia requires expert testimony to establish the element of medical causation. *See, Williams,* 681 A.2d at 1150–1151. Therefore, if this Court finds in favor of these Defendants and excludes Dr. Cantu and Dr. Vollmar's causation opinions as unreliable, then these Defendants are entitled to summary judgment.

4. David L. Higgins, M.D. Is Entitled To Summary Judgment Because There Was No Physician-Patient Relationship.

Assuming arguendo, Plaintiff's claims against Dr. Higgins survive despite the arguments set forth above, Plaintiff would still not be able to recover against him because he had no physician-patient relationship with the Plaintiff.

It is clear from the facts established through discovery in this case that Dr. Higgins never provided treatment and care, or even evaluated the Plaintiff. Plaintiff's allegations as to Dr. Higgins are unsupported by the facts established in this case. A patient-physician relationship never existed between Dr. Higgins and the Plaintiff; therefore, the Plaintiff has failed to establish that Dr. Higgins owed her a duty of care.

a. *Physician-Patient Relationship Required for Duty to Exist*

It is well-established District of Columbia law that in order for a Plaintiff to prevail in a claim for negligence, the Plaintiff must establish: "(1) a duty owed by the defendant to the plaintiff, (2) which defendant breached, (3) and that the breach proximately caused plaintiff's (4) damages." *Feirson v. D.C.*, 362 F. Supp. 2d 244, 250 (D.D.C. 2005), aff'd, 506 F.3d 1063 (D.C. Cir. 2007) (citing *Haymon v. Wilkerson*, 535 A.2d 880, 881 (D.C. 1987).

In this case, all of Plaintiff's contentions that Dr. Higgins owed her a duty of care to support her negligence claim stem from what would be a physician-patient relationship. District of Columbia Courts have recognized under certain circumstances a physician-patient relationship may create a duty of care. *Newmyer v. Sidwell Friends Sch.*, 128 A.3d 1023 (D.C. 2015) (quoting *Dehn v. Edgecombe*, 384 Md. 606, 865 A.2d 603 (2005). The Court stated:

> "a physician-patient relationship may be established by examining the patient, independently reviewing or analyzing a patient's medical records, engaging in a continuous course of treatment, rendering a medical opinion, or controlling a patient's course of treatment."

Newmyer v. Sidwell Friends Sch., 128 A.3d 1023, 1034 (D.C. 2015) (citing *Gilbert v. Miodovnik*, 990 A.2d 983, 991 (D.C. 2010).

During the Plaintiff's deposition, when asked regarding her interactions with Dr. Higgins during the time period of her alleged concussive injury, the Plaintiff stated:

> Q. And I assume you never saw Dr. Higgins during any of this time frame.
> A. I didn't see him for this.
> Q. Did you see him for anything else?
> A. I don't remember if this is during this period or not, but I went to him once for like a cold or something, those types of things, but that was the only time.

See, Exhibit 3 at 199:6-13.

Plaintiff, by her own testimony, indicates that she did not have any physician-patient relationship with Dr. Higgins that would establish that he owed her a duty of care following her alleged injury on September 23, 2011.

Dr. Higgins offered corresponding testimony at his deposition:

> Q. All right. Doctor, did you ever see Jennifer Bradley?
> A. No, sir. I don't have any recollection of seeing her.
> Q. Do you recall ever talking about her with anyone?
> A. No, sir.

See, Exhibit 6 at 69:13-19.

In this case, there are no facts to support that Plaintiff was ever evaluated by Dr. Higgins, or that Dr. Higgins ever reviewed or analyzed the Plaintiff's medical records. The facts support that Plaintiff was evaluated by Dr. Williams, and multiple other healthcare providers at various times following her alleged injury. Dr. Higgins never administered any medical treatment and care to the Plaintiff and therefore did not owe any duty to the Plaintiff.

b. *Dr. Higgins Did Not Have A Duty To The Plaintiff To Learn What Dr. Williams Knew About Concussions.*

The Plaintiff has failed to establish any facts to support her contention that Dr. Higgins, individually, acted in any manner that would render his actions as medical malpractice, or that he owed any duty to the Plaintiff to learn the extent of Dr. Williams' knowledge regarding concussions. Therefore, Dr. Higgins had no duty to learn what Dr. Williams knew about concussion care and treatment.

During his deposition, Plaintiff's expert, Robert Cantu, M.D. testified that he knew Dr. Higgins did not treat the Plaintiff and did not know about her condition after the September 23, 2011 field hockey game. He testified that Dr. Higgins' negligence was his failure to learn what Dr. Williams' knowledge of concussion care and treatment was. Specifically, Dr. Cantu testified:

> A. . . .He, because he is responsible for the care of athletes, is responsible for the care of people under him.· And that's where I feel that he does bear a responsibility for the inappropriate care that Dr. Williams delivered. I realize completely that Dr. Higgins did not see this patient and was not aware of this patient's condition, but this happened all on his watch. And if he was going to have somebody be responsible for this athlete's care, then he had a responsibility to know that this person had the knowledge to deliver correct care.· And, obviously, that wasn't demonstrated in this case, at least in my opinion.

See Deposition Transcript of Robert Cantu, M.D. at pp. 87:14-25 and 88:1-3, hereto attached as *Exhibit 7*.

Plaintiff's expert's testimony exhibits his lack of understanding of Dr. Williams's role. Dr. Higgins was not responsible for the care and treatment that Dr. Williams provided to the Plaintiff, or for any other patient that he did not evaluate or know anything about. (Emphasis supplied).

The at-issue care related to the Plaintiff's allegations against Dr. Higgins involved care and treatment provided by Aaron Williams, D.O. At the time of the alleged occurrence, Dr. Williams

was a board-certified, military trained physician who was completing a fellowship in sports medicine through the National Capital Consortium. *See* Memorandum of Understanding, hereto attached as *Exhibit 5*. At no point in time did Dr. Higgins interview, select or hire Dr. Williams for a fellowship within his practice.

At his deposition, Dr. Higgins testified:

Q. Okay. So am I correct in that the consortium would be the ones who would interview and decide who was going to get the fellowship?
A. Yes, sir.
Q. And then they give them to you?
A. Yes, sir.

See, Exhibit 6, at 51:1-4.

During Dr. Williams' deposition, Dr. Williams indicated that he never discussed the Plaintiff, or her treatment and care with Dr. Higgins:

Q. Are you able to say that you did not discuss anything with him about Jennifer Bradley?
A. I did not discuss anything about Jennifer Bradley with him.
Q. And why would that be?
A. Because that was out of the scope of his practice. Because as an orthopedic surgeon, he handles the musculoskeletal side. As an orthopedic sports medicine doctor he does not handle concussions, primary care sports medicine does.

See, Exhibit 4 at 45:20-46:5.

Further, Dr. Williams was an experienced physician who previously treated patients with concussions:

Q. Okay. Prior to your going to AU, were you aware of this -- this issue of concussions and subsequent injuries?
A. Yes.
Q. Okay. And how did you become aware of that?
A. Through my work through the military.
Q. Okay.
A. I saw a lot of concussions in the military, especially when I was deployed. I became very familiar with recognizing, diagnosing and treating them.

See id at 52:9-20.

There is no evidence that Dr. Higgins was required to learn what Dr. Williams knew about concussions. Dr. Higgins did not select Dr. Williams to participate in a fellowship at his practice. Dr. Williams was acting in his capacity as a board-certified family medicine physician and clearly had sufficient clinical background to treat concussions. Consequently, there are no facts to establish that Dr. Higgins owed Plaintiff a duty in relation to care and treatment provided by Dr. Williams. Even assuming such a duty existed, Plaintiff's allegation fails to create a genuine issue of material fact. Dr. Higgins did know that Dr. Williams was a board-certified military-trained family practitioner who had been accepted into the fellowship. Further, there is no testimony as to how Dr. Higgins' knowledge of Dr. Williams' knowledge is in any way causative of any injury to the Plaintiff. Accordingly, Dr. Higgins is entitled to judgment as a matter of law.

In sum, Dr. Higgins did not owe the Plaintiff any duty following her alleged injury on September 23, 2011 because he never evaluated or provided treatment and care to her to establish any kind of physician-patient relationship. Thus, there is no basis for Plaintiff's medical malpractice claim against Dr. Higgins in his individual capacity. Accordingly, for the reasons stated above, summary judgment must be granted in favor of the Defendant, Dr. Higgins, in his individual capacity.

CONCLUSION

In sum, for these reasons stated *supra*, summary judgment must be granted in favor of these Defendants. American University met any duty owed to the Plaintiff, her claims are barred by multiple affirmative defenses, her medical experts cannot establish causation, and there was no physician-patient relationship with Dr. Higgins. Accordingly, summary judgment at this stage of the litigation is warranted.

Respectfully submitted,

WALKER, MURPHY & NELSON, LLP

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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing Memorandum of Points and Authorities in Support of Motion for Summary Judgment was served electronically this 31st day of October, 2019 to:

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JENNIFER BRADLEY,	*	
Plaintiff	*	
v.	*	**Case No: 1:16-CV-00346 (RBW)**
NCAA, et al	*	
Defendants	*	

ORDER

UPON CONSIDERATION of Defendants' Motion for Summary Judgment and Supporting Memorandum of Points and Authorities, and any opposition thereto, it is this _____ day of _____, 2020, by the United States District Court for the District of Columbia hereby:

1. That Defendants' Motion for Summary Judgment is hereby GRANTED; and
2. ORDERED that judgment is entered against the Plaintiff in favor of the Defendants.

_____
JUDGE, United States District Court
for the District of Columbia

EXHIBIT

1

DEPARTMENT OF ATHLETICS

2011-2012 CONCUSSION STATEMENT

I understand that participation in intercollegiate athletics includes the risk of injury; including but not limited to serious permanent injury and death. I further understand that there is a possibility that participation in my sport may result in a head injury or concussion. I have been provided with education on head injuries and understand the importance of immediately reporting symptoms of a head injury/concussion to the Sports Medicine Staff.

To minimize the risk of injury, I agree to obey all safety rules, to report fully any problems related to my physical condition to appropriate University personnel including medical personnel and coaches, to follow prescribed conditioning programs and to inspect my athletic equipment daily.

After reading the NCAA Concussion Fact Sheet and the Department of Athletics Concussion Management Plan, I am aware of the following:

- A concussion is a brain injury, which I am responsible for reporting to my sports medicine staff (e.g., Staff Athletic Trainer, Team Physician).
- A concussion can affect my ability to perform everyday activities and affect reaction time, balance, sleep and classroom performance.
- I cannot see a concussion but I might notice some of the symptoms right away; other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion I am responsible for report the injury to my Staff Athletic Trainer or Team Physician.
- I will not return to play in a game or practice on the same day when I have been diagnosed by the Sports Medicine Staff with a concussion.
- In rare cases repeat concussions can cause permanent brain injury, brain damage and even death.

My signature below indicates that I have been provided with specific educational materials on what a concussion is and been given an opportunity to ask questions about areas and issues that are not clear to me.

Jennifer Bradley Print Athlete's name	Jennifer Bradley Athlete's Signature
Parent/Guardian (If athlete is under 18)	Date

EXHIBIT

2

DEPARTMENT OF ATHLETICS

2011-2012 ACKNOWLEDGEMENT OF RISK

I desire to participate in the sport identified below ("Sport") at American University ("University"), and, in consideration of being allowed to participate in the sport, I hereby acknowledge and agree as follows:

I acknowledge that I am participating in these activities voluntarily.

I have consulted with a medical doctor regarding my personal medical needs. I represent that I am fit to participate in sport related activities and that there are no health-related reasons or problems, which preclude or restrict my participation in sport related activities.

I understand that participation in intercollegiate athletics involves a risk of injury which may range in severity from minor to catastrophic, including, but not limited to serious permanent paralysis, bone/joint or other bodily injury, concussions, other chronic disabling conditions and even death. I further understand that such injuries may occur in the absence of negligence.

To minimize the risk of injury, I agree to obey all safety rules, to report fully any problems related to my physical condition to appropriate University personnel including medical personnel and coaches, to follow prescribed conditioning programs and to inspect my athletic equipment daily.

My signature below indicates that I am aware of the risks of injury inherent in athletic activities and that such risks may include death, paralysis and other serious permanent bodily injury. I am willing to assume responsibility for any and all such risks of injury while participating in intercollegiate athletics at the University.

I (including my parents, legal guardians, and legal representatives) hereby agree to indemnify, defend and hold harmless the University and its employees, officers, agents from any claims, demands, or suites for damages which may arise from my participation in the University's intercollegiate Athletic Program; of from any treatment, medical, or otherwise provided to me by the University's Sports Medicine Staff. Further, I absolve, indemnify, defend and hold harmless American University from any breach of these presentations.

I understand my obligations as set forth in this document, and agree to meet these obligations as a condition of my participation.

Field Hockey	7-25-11
Sport	Date
Jennifer Bradley	
Print Athlete's Name	
Jennifer Bradley	
Athlete's Signature	
Parent/Guardian (if athlete is under 18)	

EXHIBIT

3

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JENNIFER BRADLEY, :
Plaintiff, :
v. : Case No.:
NCAA, et al., : 1:16:CV-00346 (RBW)
Defendants. :

Deposition of JENNIFER BRADLEY
Washington, D.C.
Tuesday, November 21, 2017
10:14 a.m.

Reported By: Keith A. Wilkerson

Deposition of JENNIFER BRADLEY, held at the offices of:

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(202) 851-9899

Pursuant to notice, before Keith A. Wilkerson, Notary Public in and for the District of Columbia.

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A No.
Q Why did you select American University?
A Well, obviously it's a good academic institution, and I like D.C., but mostly because I liked the field hockey team and I wanted to play field hockey.
Q Were there any other schools that you were seriously considering besides American?
A Yes.
Q Which ones were sort of the top list, if you will?
A James Madison, Syracuse and AU were my top three.
Q Was it in that order or was there any specific order?
A Well, AU won, so I guess they were number one. James Madison was probably second, but they were pretty even in my head.
Q And I'm just trying to get a sense for why you chose AU. Did you get in there first? Did you get more money? How did you choose AU versus James Madison or Syracuse?
A I felt that James Madison didn't have a strong academic reparation, and Syracuse, I didn't really -- when I went to visit them I didn't really

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connect with the team, if that makes sense.
Q Did you get into both of those other schools?
A I applied to only American University.
Q So this was kind of like before you even got the applications and --
A This was my junior year of high school.
Q Did you apply early admission to American University?
A Yes.
Q And so you got in, and then by virtue of that you didn't need to apply anywhere else.
A Yes.
Q Let's talk about your freshman and sophomore years at American University. How did you like it?
A I liked it.
Q How were you doing in school?
A Well.
Q How was the field hockey?
A I enjoyed it.
Q How was it working as far as what you anticipated? Was it what you expected it to be, better, worse? And I'm talking about both academics and field hockey.
A With academics I went in thinking I was

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going to do a program called health promotion, and I changed to the international studies program. I don't think I declared that until my sophomore year, though. As far as athletics -- well, can you repeat the question?
Q I'm just trying to get a general sense for how you thought it was going with your field hockey, if it was where you expected it to be, better, worse or --
A With field hockey I thought it went well. Sometimes I felt like -- well, I'm not sure. I think it went as I expected.
Q Where were you on the team rank-wise? Were you one of the better players, on the bottom, somewhere in the middle?
A My freshman and sophomore years?
Q Yes.
A I was one of the better players.
Q Were you starting your freshman year?
A Yes.
Q And your sophomore year, I assume.
A You probably know this better than me from looking on line, but the stats are on line. I didn't start all the games my sophomore year.
Q And is there a reason for that, as far as

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you know? You said that you started most of the games your freshman year. Correct?
A Yes, I think. Did I?
Q Actually, the statistics don't show whether you were a starter or not.
A Yeah, they do.
Q Then I missed that part of it. So tell me your understanding as to why you may not have started as much your sophomore year.
A How do I understand it?
Q Yes.
A Because my coach, we called him Steve, he was, I don't know, making decisions, I guess, between me and another player, trying out who was better.
Q Who was that other player?
A Shay.
Q Outside of field hockey and academics, what were your interests your freshman and sophomore years?
A I didn't have much other time.
Q When I looked at your grades it looked like your first semester was your lowest GPA.
A Possibly.
Q Was there any reason for that? Do you recall anything happening that semester?
A I don't believe anything happened. I think

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it may have been an adjustment period.
Q After that first semester did you feel like you were getting adjusted to college life?
A Yes.
Q Let's talk about the field hockey process as you remember it. As I understand it, there's a team meeting at the beginning of every season. Correct?
A Yes.
Q What do you remember about the start of season meeting or whatever you guys called it?
A The pre-season meeting before we began practicing?
Q Right.
A They were long. I believe they were called compliance meetings. We had people come and talk to us about, you know, different administrative things. We had to sign papers. I know that I signed concussion papers. There were other NCAA papers. They went through a lot of things. Our trainer, Sean Dash, would speak to us. We also got all of our equipment, our clothing and shin guards, that type of stuff.
Q Let me ask you: Specific to concussions, what kinds of things were you told or do you remember being told about concussions?

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A What I remember is Sean Dash -- you've met Sean Dash?
Q Yes, we all have.
A He came in and spoke to us and had us sign a paper. He's not a very -- he just kind of speaks and leaves the room. He didn't really speak much to us.
Q What was the substance that you gleaned from his meeting on concussions?
A That if you're experiencing certain symptoms to tell your trainer.
Q What types of symptoms?
A I can't tell you what he told us.
Q At the pre-season meeting was Jenna Earls there as well?
A What year?
Q Either your freshman, sophomore or junior year.
A No, she was not during my freshman year. We had a different trainer, and in my sophomore year we also had a different trainer.
Q What about at the pre-season meeting at the start of your junior year? Would Jenna Earls have been at that meeting?
A Yes.
Q Would she have talked at all, or was it only

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Sean Dash that was doing that part of the presentation?
A She spoke to us because she was a new trainer and wanted to introduce herself, but I don't remember what she said.
Q You don't recall the substance, other than just an introduction?
A Correct.
Q Other than signing some forms and Mr. Dash's presentation, is there anything else that you remember about concussion protocols or what to look for and what to do?
A No.
Q Putting aside whatever you may have been told at American University, what was your general understanding back in -- I'll make it right before September 2011. So coming into that junior year season what was your understanding of signs and symptoms related to a concussion?
A My understanding before that year?
Q Going into that year, right.
A Well, that's a difficult question for me to answer because now after all of this I know so much about concussions, and I don't know exactly how much I knew before.

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Q And that's fine. If you don't understand any of my questions or you don't know how to answer any of my questions, please let me know.
A What I would say is that I knew as much as Sean Dash would have told us, and I'm sure you could probably find the paper that I signed.
Q I'll show you that in a moment. Did you ever do any sort of research or anything on your own prior to September 2011 about concussions?
A No.
Q In all of your years of playing field hockey in high school did you ever have any understanding that concussions could be associated with field hockey play from high school?
A I think I understood that with any physical activity there's a chance to get injured to any part of your body.
Q At the high school level would any of your coaches or trainers talk to you and your fellow teammates about concussions and what to look out for and what to do?
A I don't remember.
Q You were also on some national teams. Is that correct?
A I was on a national team?

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Q I'm asking. Were you ever on any sort of national team at the high school level?
A Are you familiar with the Futures Program?
Q Only what I've read here and there, so not very much.
A Would you like me to explain it to you?
Q Please.
A There's college field hockey, NCAA, and then there's high school field hockey and then there's the U.S. Women's National Team program. There's a program called Futures, and I believe you have to try out for it. It's just really in the winter, I think. On Sundays you practice, and it's people from all around the area. And then there's this big tournament, and I forget what it's called, but it was usually at Virginia Beach, but that was something that I played on. I was also in the Junior Olympics. You get chosen from those tournaments. And that continues into -- it's not just high school. It continues into higher levels as well.
Q I just want to make sure I'm following you. At the high school level you played on one of these teams for the Futures program and also the Junior Olympics. Is that correct?
A The Junior Olympics is just a tournament.

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It was during the summer, and I played in that tournament.
Q And as far as the Junior Olympics or the Futures Program, did you do either of those in college?
A The Futures Program I did when I was in college.
Q With the Futures Program and/or the Junior Olympics did you ever have any sort of training or education on concussions as it related to field hockey?
A I don't believe so.
(Bradley Deposition Exhibit 2 marked for identification and attached to the deposition.)
Q You mentioned some documents, and I'm going to show you two documents which I'm marking Exhibit No. 2. These are not the best of copies. I'm going to ask you to take a look at both of those pages, and then I'll just ask you if that is your signature on both of those documents and if those appear to be some of the forms that you filled out at the pre-season meeting that was talking about concussion protocols.
MR. NACE: I object to the question. Do you want to know if it's her signature?
MR. MURPHY: Sure. We'll start there.

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BY MR. MURPHY:
Q Is that your signature?
A Yes.
Q How about on the second page?
A Yes.
Q Now, you mentioned earlier that there were some forms which were handed out which you would have to sign that were talking about concussions. Correct?
A Yes.
Q Do these appear to be some of those forms, or do you recall different forms?
A Can I read them?
Q Absolutely. Again, I apologize that they're not the best copies.
MR. NACE: So the question is do those appear to be the forms that she signed?
BY MR. MURPHY:
Q Are those the forms you remember going over with Sean Dash or whoever it was at the pre-season meetings about concussions and the risks?
A My signature's on them.
Q You mentioned earlier that you recall filling out forms.
A Yes.
Q And my question is: Do these appear to be

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those forms, or do you have a different memory of some other types of forms?
A There are other types of forms, like what's your address, what's your year, what's your major, and I had to fill those out as well.
Q Specific to the risks attendant to playing field hockey and concussions in particular do you remember any different forms?
A No.
Q Prior to the Richmond game in September 2011 had you ever had any injuries playing field hockey for American University?
A Prior to 2011?
Q Right.
A There was one time when I hyperextended my knee, but I don't know if that was before 2011. It might have been that same season.
Q When you hyperextended your knee, what did you have to do for that?
A I wore a brace.
Q And did you miss any playing time?
A No.
Q Other than wearing a brace for a hyperextended knee, do you remember any other type of injuries related to field hockey at American

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A No.
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A Prior to 2011?
Q Right.
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Q When you hyperextended your knee, what did you have to do for that?
A I wore a brace.
Q And did you miss any playing time?
A No.
Q Other than wearing a brace for a hyperextended knee, do you remember any other type of injuries related to field hockey at American

Page 41

University prior to the Richmond game?
A Well, you know about the ankle. That was in high school, but I still taped it during college. Nothing's really standing out in my memory. I'm sure there were little things like maybe skin abrasions. You always get cut up and stuff because the turf is hard. I don't think there was anything major.
Q Do you remember ever having to miss time from practice or games outside of maybe a missed practice here and there because you didn't feel good or something like that?
A No.
Q Let's talk about the Richmond game on September 23rd of 2011. That's the game when you're alleging you sustained a concussion. Correct?
A Yes.
Q Tell me, first of all, when in the game you think you got a concussion.
A I believe it was in the first half, but I can't say for sure. That was a pretty long time ago, but that's when I believe it happened.
Q And how long are the halves?
A It's been a while. I believe they're 30 minutes, but they could be 25 minutes.
Q Can you give me some sense of when in the

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first half? Was it early, midway, late?
A No.
Q What happened that you believe led to the concussion?
A Are you familiar with field hockey?
Q Not as familiar as I should be at this point, but a little bit. I've seen some of the tapes.
A You've only seen tapes? You've never seen a game in person?
Q I have not been to a field hockey game yet, no, not in person.
A Do you know that you can only use one side of the stick?
Q Yes.
A So I was going down for a reverse block tackle. Do you know what that means?
Q I have a general sense, but why don't you explain it to me?
A You're holding the stick like this with the flat side out (indicating), and if someone's coming at you this way (indicating) there's something called a reverse block tackle where you have to put the stick just in one hand. Usually it's shaped up like this, and then it goes like this and the flat side is down (indicating). So then that means also that you're

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very far down to the ground.
A girl was coming at me, an opposing player with the ball, and her shoulder collided into my face, my head. And I remember going up like this (indicating), and then I remember that she beat me, that she got past me. I remember standing up and kind of, you know, going like that (indicating). Then Steve told me to go back and get the ball, so I went back and got the ball.
Q Just for the record, you were pointing to the right side of your face. Is that where the contact was?
A Yes. That would make the most sense because if you're coming at me and I'm down like this, that shoulder would be here (indicating).
Q And by "that shoulder" you're referring to the opposing player's right shoulder?
A Yes.
Q Where were you on the field?
A I was on the right side of the field. The field's like this (indicating), and it was more in the center part. We weren't close to either goal.
Q So center more or into the right side of the field from your goal's perspective. Is that correct?
A Yes, and that's just from my recollection.

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I have not seen a tape to confirm that.
Q Do you have any recollection of the other player, any details, what her number was, what she looked like, anything at all?
A No.
Q Was your sideline on the right side closest to you or away from you?
A The right side.
Q So you were closer to your team's sideline. Is that correct?
A Both teams are on the same side.
Q Did you continue to play the remainder of the half?
A Yes.
Q Did you come out at all during that half, to the best of your knowledge?
A I don't believe so.
Q Did you have any difficulty playing the remainder of that half?
A From what I remember, I remember being a little -- I would describe it as being a little off, a little bit out of it.
Q Can you be any more specific as to how you felt or what you mean by a little bit out of it?
A What I felt was that my coach wanted me to

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go back and get the ball, and that's what I thought about.
Q Obviously that's just that instant play that you're talking about when he was telling you to go back and get the ball. Right?
A It wasn't so instant, because when she got past me I had to go back on defense.
Q Did you ultimately go back to defense?
A I think I ran back there. I don't know how much of a help I was.
Q Do you know how that play ultimately ended? Did it result in a goal?
A I don't remember. I'm sorry.
Q Can you give me a sense for how long you continued to play in that half? Was it five minutes, 20 minutes?
A I'm really not sure.
Q At halftime how were you feeling?
A I don't remember.
Q Did you have any conversations with Coach Jennings, Ms. Earls or anyone else with the coaching or training staff at American University?
A When?
Q At the halftime if that Richmond game.
A Did we speak?

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Q Do you have a recollection of --
A Yeah. I mean, they spoke to us about the game.
Q Did you have any specific conversations about how you were feeling with any of your teammates, coaches or trainers?
A I did not speak to the coaching staff or the trainers.
Q Did you play in the second half?
A Yes.
Q How did you feel in the second half?
A I don't remember.
Q After the game did you have any discussions with the coaching staff or trainers about how you were feeling?
A No. We lost the game and everyone was not in a good mood.
Q I'm assuming you took a bus back from Richmond.
A Yes.
Q At any point during the remainder of that day, on the trip home when you get back to American University and did whatever you do to get ready to leave the athletic facility, did you have any conversations with any coach or training staff about

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how you were feeling or about what happened during the game to you physically or anything like that?
A On that day?
Q Yes.
A I don't believe so.
(Bradley Deposition Exhibit 3 marked for identification and attached to the deposition.)
BY MR. MURPHY:
Q I'm going to show you what I'm marking as Exhibit No. 3, and I'll ask if you can identify it.
A This is a timeline.
Q Who created this timeline?
A I did with my mom.
Q When did you and your mom create the timeline?
A Can I look through it?
Q Absolutely.
A It looks like we stop in August of 2012, which is probably when we made it.
Q To the best of your knowledge, was this timeline made all at the same time? In other words, whatever that date was in August did you sit down with your mom and try to go back from the Richmond game and put as much detail as you could into it?
A Yes.

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Q And I don't want you to tell me anything that your attorneys may have discussed with you, but what is the reason why in August 2012 you and your mom sat down to try and create a timeline?
A Because I was having memory problems from my head injury and I wanted to remember what happened to me.
Q What did you do or what did you review to try and put this timeline together in August 2012?
A Let's see. It looks like we went through e-mails. It looks like we looked at the schedule on line. It looks like we went through doctors' notes from my own doctors in Lancaster and my doctors here. It looks like we talked about phone conversations, bills.
Q I guess what I'm trying to understand is whether the things that are put on the timeline, if you actually reviewed the documents yourself to --
A Yes.
Q So this wasn't something you were doing by memory. Correct?
A No, it wasn't.
Q The next game, as I understand it, following Richmond was the Boston College game on September 25th. Is that your recollection as well?

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A Yes.
Q Did you play in that game?
A Yes.
Q According to the box scores I believe you scored a goal in that game. You wouldn't have any reason to dispute what's in the box scores, would you?
A I scored.
Q Do you remember scoring?
A I actually do remember scoring.
Q What else do you remember about the BC game other than scoring a goal?
A It was at home, I think. That's about it.
Q Did you have any problems playing in the BC game?
A Well, from my recollection when I wrote this it says that I did.
Q And we don't have to read it, but it says that you had vision problems, concentration and fatigue. Were there any other signs or symptoms that you recall experiencing during the BC game?
A No. I think that this recollection is probably better because it was -- it's been very many years, and that was just one day.
Q And when you say the recollection you've written down in Exhibit 3 is better, you're saying

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that because you did that in August 2012 as opposed to today in 2017. Correct?
A Yes. It was more fresh in my mind.
Q What I'm trying to understand is: Did you review anything specific as to the September 25th game to come up with those symptoms, or is that based on your memory in August 2012?
A I can't recall what we may have reviewed for that.
Q Am I correct that prior to the Boston College game you had not had any discussions with coaches or training staff about any physical conditions you were experiencing?
A I did not prior to that game.
Q How about after that game? That day, either at halftime or after the game was over, did you have any conversations with coaches or trainers about how you were feeling?
A After that game? I can't really remember. I can't remember what game it was after. I just remember that we sat there and I talked to Sarah first. Do you know who Sarah is?
Q Was it Sarah Thorn, which I think is her last name?
A Sarah Thorn Krombolz, and then from Sarah I

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immediately went to Jenna, my trainer.
Q And I'll get to that in a second. Did your parents typically go to your games?
A Yes.
Q To your knowledge, were they at the Richmond game?
A They were not.
Q Were they at the BC game?
A I would say probably, but I'm not entirely sure.
Q On October 1st was the Lehigh game. Correct?
A It looks like it, yes.
Q As I understand your timeline, it was after the October 1st game with Lehigh that you had your discussion with Jenna and Steve Jennings. Correct?
A Yes. According to the timeline, yes.
Q And when I went back and I looked at the American University records -- and we're going to go over them in a minute -- Jenna has documented that you came to her after the October 2nd game against Temple, and that that was the first time you told her about any of your signs and symptoms.
The question that I have for you at the moment is: Do you have any way of refuting that or

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stating that it was October 1st as opposed to October 2nd when you had that conversation?
A Do I have any way of refuting that?
Q Right.
A What would be a way to refute that?
Q Well, a specific recollection like, I know it was after the October 1st game, or, I've got a document, an e-mail, a text message, or, My mom remembers it.
A My mom may have remembered it.
Q As you sit here today, other than any memory your mom might have, do you have any way of saying that it was the October 1st game when you told them as opposed to the October 2nd?
A Can you tell me if Temple was home or away?
Q I believe they were both at American University.
A Because I know it was at a home game.
Q So you know it was at a home game?
A Yes. To my recollection, I told Jenna and Sarah and Steve, and then the next day we had another game, which would make sense if it was October 1st. The next day we had another game.
Q So looking at the schedule, I believe October 1st was Lehigh at home and October 2nd was

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Temple, and they were both home games. Okay?
A Okay.
Q From the memory that you have, who did you go to first?
A Sarah.
Q And what did you tell Sarah?
A I don't remember the exact words.
Q As best as you can recall, what did you tell Sarah and what did she say to you?
A As I remember, I told her that there was something wrong and that I couldn't think or analyze the game in the way that I usually do and that I was having some vision problems and was becoming very fatigued. That's what I remember. And then did you ask me what I did after that?
Q Well, what was Sarah's response after you told her that?
A Sarah told me to talk to Jenna.
Q And did you talk to Jenna?
A I did talk to Jenna. I don't remember that conversation being long at all. I don't have much of a recollection of it. I know I did talk to her because Sarah told me to, and I listened to her.
Q And what do you remember telling Jenna? Was it any different than what you told --

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A I would have told her exactly what I told Sarah.
Q Do you remember what Jenna's response was?
A No.
Q When in the sequence of things did you speak with Steve?
A That day.
Q Was it before or after or in between Sarah and Jenna?
A After.
Q And what did you tell Steve?
A I would have told him the same thing.
Q And what did he respond?
A Well, we did speak for a while. The things that I remember from the conversation were that I should eat a little bit more, that my sugar may be low, and that I should have a bowl of ice cream that night.
Q Had you ever had any issue with blood sugars in the past?
A I did have -- what is it called?
Q Hypoglycemia?
A Yes.
Q Did you have any treatment for hypoglycemia?
A I took those little sugar glucose tablets,

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and I always had them with me.
Q Did you tell Sarah, Jenna or Steve when these symptoms began?
A The hypoglycemia?
Q The vision, difficulty analyzing and fatigue.
A I told them how long it had been going on.
Q And how long had it been going on?
A It would have been about a week, give or take.
Q And those symptoms, the analytic difficulty, the vision and the fatigue, had they started immediately during that incident in the first half of the Richmond game and continue nonstop or did they wax and wane? How did they go?
A It was not immediate. The way that I understand concussions to work, it's not always that you just get knocked out and you're just bleeding on the field and everyone knows it. And everyone's brain is different. I can't say how frequently everything happened. It was a while ago. I just know that there was a line in between.
Q I guess what I'm trying to understand is when you're having this conversation with Sarah, Jenna and Steve -- and if you don't remember that's fine, I

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just need to know what you remember -- did you tell them it's something that's been going on since Richmond or that it's something that's been going on for the last day or two? What did you tell them in that sense?
A I don't remember if I told them how long. I remember telling them that it had been going on, which would mean more than just that hour, but I can't recall the words I used. It was a long time ago.
Q Did you have any discussion with them about being hit in the head at the Richmond game?
A At some point we had a discussion, but I don't know if it was that day.
Q The hit in the Richmond game, was it anything different than other hits that you'd taken in other games throughout the years of playing field hockey?
A In what way?
Q Did it seem different to you in any way, the impact, the velocity, anything at all like that?
A It made me, you know, stand up and kind of feel very out of it, which was different. That's not normal.
Q But the hit itself, was it different than what you'd experienced in the past? Did the player

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run at you faster, hit you harder? Was the collision more violent than anything you'd experienced in the past, anything like that?
A I don't know how to answer that. If I were to punch you in the arm now, tomorrow would you really know the difference?
Q Did it stand out in your mind as being unusual at the Richmond game?
A Yes.
Q And is that because of how you felt afterwards or because of how the hit was?
A It was because of how I felt after I was hit, just standing up, and that's not a normal reaction for me.
Q The discussion that you first had with Sarah, when was it in relation to the game? Was it before the game, after the game --
A Whichever day before that game it -- is that what you're asking?
Q Yes.
A It would have been immediately after the game.
Q So the first time that you said anything to Sarah would have been after whatever game it was in early October that you had the discussion. Correct?

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A Yes.
Q And I just want to make sure I'm correct about this. Sarah is the first person with American University that you'd had the discussion with. Correct?
A Yes.
Q Had you reported any of these signs or symptoms to your parents before telling Sarah?
A I would say probably.
Q Do you have a recollection of that, or are you just kind of saying that that's probably what you would have done?
A I don't have a strong recollection. I know I spoke about it.
Q I assume between the Richmond game and whenever you had this conversation with Sarah that you had made all the practices for field hockey. Correct?
A Yes.
Q After you had the discussion with Steve, other than him telling you to eat a bowl of ice cream that night, was there anything else that he recommended you to do?
A He may have told me to get a good night's rest.
Q Was there ever any discussion about seeing a

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doctor?
A That day?
Q Yes.
A No.
Q Is there a team doctor at the home AU field hockey games?
A Sometimes.
Q Do you have any recollection sitting here today of whether or not there was a team doctor at the Lehigh or Temple game?
A I don't believe there was.
Q Why do you say that?
A The doctors didn't usually come to the games. We just had our trainers.
Q You said that sometimes they do come, though. Correct?
A Yes. If somebody has an injury or something maybe they'll show up at the game, but they were never really part of any pre-game rituals or practices or anything like that.
Q So what do you remember happening next following your discussion with Steve? When is the next time you played field hockey?
A I would say that it was the next day in that game.

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Q And you're assuming that the discussion was on October 1st, after the Lehigh game. Correct?
A Yes.
Q Did your mother accompany you to any of these discussions with Sarah, Jenna or Steve?
A No.
Q Where would your parents stay when they were in town? For that weekend I'm assuming they were here for both games. Correct?
A It was just my mom who came that weekend, and she stayed in a hotel.
Q The Temple game on October 2nd, how did you do in that game?
A I don't remember.
Q You don't recall anything about how you played?
A Did I score?
Q I don't think so, but don't hold me to that.
A I don't remember.
Q I think you had three shots on goal but no goals or assists. You don't remember?
A I don't remember.
Q And I had alluded to this earlier. The records that Jenna has says that you approached her after that Temple game on October 2nd and that that

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was the first time that you had had the discussion. Other than what you've told me, do you have any way to disagree with that, that the discussion was after October 2nd and not after October 1st?

A The reason why I believe that to be true is because I remember my conversation with Steve, that he told me to eat ice cream or whatever and to get a good night's rest because we had a game the next day. That's the conversation I remember happening.

Q And you recall it specifically as, We have a game tomorrow, not as, We have practice tomorrow, something like that?

A No, we had a game, because that Monday we wouldn't have had practice because we have to have one day off a week.

Q And you then wrote an e-mail to Jenna documenting your symptoms. Correct?

A Yes.

Q Why did you write that e-mail to Jenna?

A Because I felt like she wasn't listening to me and that I wasn't getting the proper attention that I needed according to how I felt.

Q Had you interacted with Jenna prior to that?

A Yes. She had introduced herself at the pre-season meeting.

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Q Had you had any substantive conversations with Jenna prior to this?

A Well, she taped my ankle, so we talked while she was doing that.

Q Did you have a decent enough relationship with Jenna?

A I thought she was a nice person.

Q After you wrote the e-mail to Jenna what happened next with respect to your interaction with the training staff?

A After I wrote the e-mail, it was then that she said I could see a doctor.

Q And did you then go see a doctor?

A She made an appointment for me. It happened a few days later.

Q During those days in between did you practice, aside from that Monday which you would have had off?

A Yes, because I was cleared, and if you're cleared you have to practice.

Q What did your parents say about you practicing -- I'm assuming by the time you told Steve you would have told your parents for sure. Correct?

A Yes.

Q What did they say about whether or not you

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should practice?

A I don't know what they said about practice. I know they were worried.

Q What did they say about playing the game?

A I don't know.

Q Did you have a discussion with Jenna after the e-mail to her with your symptoms?

A Yes, we had to have, because I would have seen her at practice and she would have acknowledged that I'd sent her an e-mail. She was the one who made the appointment for me.

Q Do you remember anything more substantive about your discussions with her?

A No. I just remember that she said that I needed to see a doctor and that she said, I'll set that up for you.

Q And what doctor did you see?

A It would have been the doctor in the training room, who I believe was Dr. Williams.

Q Had you ever met with Dr. Williams before, to your knowledge?

A No.

Q And I believe it was on October 5th, but I don't see that on your timeline. Do you have any recollection as to when the meeting was with the

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doctor?

A Do you know what day of the week October 5th would have been?

Q The 3rd would have been Monday, so --

A So the 5th would have been Wednesday, which makes sense.

Q Who attended the meeting with you and Dr. Williams?

A Jenna.

Q Did you have any discussions with Jenna during that meeting?

A During the meeting with Dr. Williams?

Q Yes.

A No. I believe she was just there because she was the field hockey trainer.

Q Tell me what you remember about that discussion, that interaction on October 5th with the doctor.

A I would have told him what the symptoms that I listed in the e-mail were, which was pretty explicit, and asked him what was wrong with me.

Q Did you give any history related to the Richmond game or any sort of contact to the head?

A At some point I did. I don't know if it was that day.

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Q That afternoon or at some other --
A At the tailgate that followed the game.
Q So you showered and then you went to the tailgate?
A No. You go to the tailgate first. I only went there for a few minutes to find Jenna and ask her where Dr. Williams was.
Q And was this pre- or post-game?
A Post-game.
Q So you were only at the tailgate for a short time?
A Yes, because I needed to find Dr. Williams.
Q Then she says go back, that she'd be there?
A Yes.
Q Do you know if she had had contact with him that day, that afternoon?
A She must have, because we don't set up the appointments for the doctors, our trainers do.
Q And did she say anything else about why he hadn't come earlier, that he's late or that he forgot or his car broke down? Did she give you any insight?
A No, she just said, He didn't show up, go find him.
Q So your visit with him would have been, then, at what time?

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A Like I said before, between 4:30 and 5:30, perhaps. I'm not entirely sure. The game started at 2:00. Games typically last maybe an hour and a half or two hours. There's post-game, there's talking. We lost that game, so we probably talked for a while. Then there's the tailgate. There's no alcohol at a tailgate for AU.
Q I know we've asked you short term what you want to do as far as your studies and degrees, but what do you want to do long term as far as a vocation or profession?
A Like I said, I want to get my Ph.D., which is sort of a profession in itself.
Q And then?
A Well, once you get your Ph.D. you usually become a professor.
Q Is that something you'd like to do or something you could see yourself doing?
A Perhaps. I don't have a big timeline to share with you. I don't know exactly.
Q I understand. You said you would like to get your doctorate in anthropology. What do people with that degree do?
A Some people teach and some people are able to do research for other institutions.

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Q So I assume you at least thought at least that far ahead as far as what you might want to do with it.
A Yes, but I can't say specifically, I want to do this one.
Q And I assume you never saw Dr. Higgins during any of this time frame.
A I didn't see him for this.
Q Did you see him for anything else?
A I don't remember if this is during this period or not, but I went to him once for like a cold or something, those types of things, but that was the only time.
Q And you don't even recall if that was pre-September 11 or post?
A No.
Q Is there anything that does help you? Does rest help, yoga, exercise?
A Rest helps, as well as just trying different things for managing stress. I had to learn how not to get frustrated with myself when things take longer, much longer, and I can't understand things as quickly.
Q Does anything make it worse?
A Yes.
Q Such as what, other than lawyers asking you

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lots of questions?
A Anything physical with impact, impact meaning running. I can't do sports. What else makes it worse? There are lots of things. I've sort of had to adapt my brain in a way that it's sometimes hard to realize how much I've changed. Focusing for too long, not taking breaks, not getting enough rest, things like that.
Q Is there any activity that you liked to do that you can't do now?
A Yes.
Q Such as?
A Field hockey, running, sports, anything athletic, being competitive, being able to do things well, quickly, understanding them right away, things like that.
Q Do you want to do any field hockey coaching?
A No.
Q Why not?
A Because it's too difficult. I can't play anymore.
Q Well, let's assume that your playing career ended at some point in the normal course. Would you have wanted to coach?
A Yes, I probably would have wanted to.

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MR. NACE: Have you ever seen that?
A I've seen it because my lawyers showed it to me.
MR. NACE: Then I guess we can't get into that.
MS. JONES: I can still ask about it.
BY MS. JONES:
Q In August of 2010 do you recall sitting for an examination with Megan Ulsie (phonetic)?
A I don't recall, but I don't dispute that.
Q Do you know who Megan Ulsie is?
A She was our trainer.
Q She was a field hockey trainer at American University?
A Yes.
Q At the beginning of the playing season were you administered a test to assess your baseline with respect to potential concussion or brain injury?
A In which season?
Q In each playing season.
A I know that I was in my sophomore year.
Q And do you remember what you were told at that examination?
A No.
Q Do you remember what you were asked?

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A No.
Q Do you have any specific recollection of the exam?
A No.
Q When were you awarded a degree from American University?
A May 2015.
Q Since graduating from American University have you enrolled in any certification programs or any postgraduate education aside from graduate school?
A No.
Q So no continued in-classroom study?
A No.
Q Did you apply for jobs following graduation?
A I worked that summer.
Q Where did you work?
A Skinny Park Juice.
Q And where is that located?
A Lancaster, Pennsylvania.
Q Did you work there full time?
A No.
Q What were your hours?
A I'm not sure.
Q And who was your supervisor?
A Carol Campbell.

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Q Do you have her contact information?
A Yes.
Q Do you know it as you sit here today?
A No.
Q How long did you work at Skinny Park Juice?
A Just for that summer. I can't remember when I started, but I stopped before October because in October I went to Nepal.
Q And what was your wage while you were working there?
A I don't remember.
Q While you were working at Skinny Park Juice, during that time did you apply for any jobs?
A No.
Q Did you apply for any jobs in your field of study, international --
A My plan was to get international experience, so I was saving money by working at Skinny Park.
Q What do you mean when you say "international experience?"
A Experience outside of the United States.
Q Why didn't you look for jobs inside the United States in the area of international relations or international policy work?
A Because I was basically unemployable without

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having significant abroad experience with an international studies major.
Q Is it your belief that you could not obtain an entry level position in the area of international research or policy without having worked abroad?
A Could you repeat that?
Q Is it your belief that you could not find or that you would be ineligible for employment in the field of international relations or international studies without having had experience working overseas?
A It doesn't make me ineligible.
Q So why didn't you apply for jobs in your field in the United States?
A Because my plan was to go to Nepal.
Q So it was your preference to go to Nepal?
A It was a plan that I had talked to my advisor about and my professors, and it seemed like the most appropriate avenue.
Q So you would agree with me when I say that you would still be eligible to apply for and not disqualified for applying for jobs in the field of International relations or studies or policy even without having experience working overseas.
A Yes. I think it wouldn't be legal to let

EXHIBIT

4

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF COLUMBIA

JENNIFER BRADLEY

Plaintiff

vs. Case No.:

AMERICAN UNIVERSITY, et al. 1:16-cv-00346-RBW

Defendants

_____/

The Videotaped deposition of AARON WILLIAMS, D.O. was held on Friday, January 19, 2018 commencing at 10:53 a.m., Paulson & Nace, 1025 Thomas Jefferson Street, N.W., Suite 810, Washington, D.C. before Sydney R. Crawford, Shorthand Reporter.

REPORTED BY: Sydney R. Crawford

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A. What's that?
Q. In Bethesda?
A. At the USH campus, the Uniformed Service campus.
Q. It's in Bethesda; right?
A. Yes. And that was -- we did didactics either there or down at Fort Belvoir. But we were at the campus in Bethesda at least once a week.
Q. And that's where you got the classroom work.
A. We got it on both places.
Q. How much classroom work did you get done at Fort Belvoir in -- in addition to what you already told me about?
A. Another half day.
Q. Another half day?
A. Correct.
Q. So about one day a week was spent for in class?
A. In classroom.
Q. And then the other, the rest of the

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week would be spent on what?
A. Getting on-hands training either at American University or up at orthopedic group up in Maryland that I was assigned to.
Q. Okay. How many of you were involved in this class, the fellowship?
A. There was four fellows on through the military, and then we also joined with Fairfax sports medicine fellowship and they had -- they had two fellows, so there was six of us.
Q. How many were assigned to AU?
A. Me.
Q. Just you?
A. Correct.
Q. Okay.
A. Each of us had our own university that we covered.
Q. Okay. Well, what was your relationship with Dr. Higgins?
A. Dr. Higgins was the head team physician, and I worked underneath him while at AU.

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Q. Did you know him from the Uniformed Health Services?
A. No.
Q. Never went there and had any classes that he taught?
A. No.
Q. So explain to me how it came about that you first met him?
A. Because he was the existing team physician through American University and with the agreement that the fellowship had with American University, I would be working underneath him at AU, and I would be learning how to be a college team physician from him with on-hands experience.
Q. What do you mean the fellowship had -- had an agreement, what are you talking about with that?
A. So the military sports medicine fellowship that I did had an agreement with American University that we would train there.
Q. Okay. So when you say "we would train

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there," you mean you would train there?
A. Correct. Me and the fellows before me trained there.
Q. So when you went to see -- meet Higgins for the first time, was it at AU, was it at his office or was --
A. It was at American University.
Q. At American University. And he was a -- what kind of physician? What was his specialty?
A. He is a sports medicine orthopedic surgeon.
Q. Okay. So you first meet him at AU. Did he have an office there?
A. We all use the training room there.
Q. So that means he did not have an office?
A. He did not have a specific office.
Q. So I take it you didn't have an office there either?
A. No, sir.
Q. When you went there the first time and

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behalf of the military, were you, or were you?
MS. CRONIN: Objection as to form.
Q. What's the answer?
A. That's -- that's a difficult question, so in a sense --
Q. It's difficult for the attorneys too, but I'm -- I'm asking you, see what you're going to say.
A. I was getting training through them, so I was meeting them on behalf of Dr. Higgins at American University, but also on behalf of the Army, because I was using them -- because they were part of my training.
Q. They were part of your training?
A. But, let me take a step back. So the patients that I saw as general practice, okay, which is the ones that I saw without Higgins, at that time, I was a board-certified family physician.
Q. You were board-certified at that time?
A. Yes.
Q. Okay. Okay.

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A. So that stuff was well within my scope as a family medicine physician, to see the athletes for dermatology. I mean, for any general medical issue, that was well within my scope.
Q. That's not my -- my question. I mean, I'm trying to understand. You said you were seeing them on behalf of the military; right?
MS. CRONIN: Objection.
Q. Well, were you or weren't you?
A. On behalf of the military?
Q. Yeah.
A. It was part of my military training.
Q. For your training that you were seeing them?
A. Correct.
Q. Is there some reason why your being in the military would be helpful for taking care of them?
A. I had no reason, me being in the military, I had no reason to -- to help them. I was a board-certified family physician who was doing

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training.
Q. But you were in the military and you were being paid by the military?
A. Correct.
Q. Did you inform any of these students that since you were a, in your view, a military physician taking care of them, that if you made a mistake and were negligent, that they lost their trial-by-jury benefit that they were guaranteed under the U.S. Constitution?
MS. CRONIN: Objection. Calls for legal conclusion.
Q. I'm just asking if you told them this.
A. Never came up. Nor did I -- would I understand that point.
Q. You didn't know that yourself?
A. No. I'm not an attorney.
Q. Okay. So no one ever told you that if you committed negligence that injured somebody, that you would be able to have a case tried just in front of a judge without a jury. No one ever told you

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that?
A. No.
MS. CRONIN: Objection as to form.
Q. Certainly then you never told that to them, did you?
A. No.
Q. After this year was over that you spent at AU, was that like July to July?
A. Yes, sir.
Q. July to June? Did you ever see Dr. Higgins again?
A. After that, no, sir.
Q. But you would see him, like twice a week?
A. Up until then, yes.
Q. Every week, with the exception of a vacation that someone may have taken, that sort of thing?
A. Correct.
Q. Okay. Do you recall ever discussing with him anything about Jennifer Bradley?

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A. No.
Q. Are you able to say that you did not discuss anything with him about Jennifer Bradley?
A. I did not discuss anything about Jennifer Bradley with him.
Q. And why would that be?
A. Because that was out of the scope of his practice. Because as an orthopedic surgeon, he handles the musculoskeletal side. As an orthopedic sports medicine doctor he does not handle concussions, primary care sports medicine does.
Q. Well, who else handles concussion, what other kind of specialty?
A. So neurology, ER, sports medicine physicians, some pediatricians handle concussions.
Q. How about ENTs?
A. Not concussions.
Q. Do you have any recollection of Jennifer Bradley?
A. Yes. I do.
Q. Can you describe her to me?

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A. She is a -- well, now, you're really asking my memory. She is -- she's about five-six, blond-brown hair, medium build.
Q. Did you ever watch her play field hockey?
A. Yes, I did, I believe I was at some of her games.
Q. Doctor, are you familiar with something called the 2011-12 NCAA Sports Medicine Handbook?
A. Yes.
Q. How did you become familiar with that? Or how were you familiar with that?
A. That was introduced to us the beginning of our fellowship, and we were told to look through it.
Q. Had you ever seen it before 2011?
A. No.
Q. Okay. Is that something you -- you became familiar with because you were going on to a college campus?
A. Yes.

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Q. Was this something that you would have been given before you got to the campus, or did you get there and on that first day or so --
A. That was given --
Q. -- Doctor Higgins said, here, take a look at this?
A. That was given by my fellowship director.
Q. And who was your fellowship director?
A. Kevin -- would you find mind if I pull out my phone really quick?
Q. Go ahead.
A. Thank you.
Kevin Deweber is my fellowship director.
Q. I'm sorry.
MR. M. NACE: Do you want a copy of this one? I'm going to make copies quickly. Okay. If you want to. Do you all have this?
MR. NACE: We all have that document. Probably better if we make copies.

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MR. M. NACE: -- copies of it already.
MR. NACE: You don't have it?
MS. CRONIN: I do not have it.
MR. NACE: You didn't think we were going to refer to it today?
MS. CRONIN: I don't need it right now.
MR. NACE: Go make everyone copies.
Q. Well, what did this gentleman tell you, then, about the sports medicine handbook? Did he tell you it's your bible?
A. He told us to look through it, reference it when we need to.
Q. Okay.
A. Specifically for us was more the dermatologist, dermatological side, because that was more difficult out of that handbook, for like wrestling, when athletes needed to have their skin diseases covered when they couldn't -- when they could return to play.
Q. Okay. But the handbook itself, was that available to you right there in the -- at AU or

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was it something you had in your --
A. I don't know.
Q. -- in your desk?
MS. CRONIN: Objection. He was answering the question.
THE WITNESS: Yes, sir. It was -- I did not know if it was at AU. I had it in my possession, on my references, but I do not know if it was at AU or not.
Q. Did you take it to AU when you went to AU? Or was it something that you had at your home?
A. I just had it at my home.
Q. Okay. You can look at it whenever you wanted to?
A. Uh-hum.
Q. Yes?
A. And if I need to, I could look online at the school to reference.
Q. Okay. Did you ever do that?
A. Yes. I did.
Q. Did you ever do that in reference to

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Jennifer Bradley?
A. No.
Q. Can you give me an idea about how many times throughout the year you might have done that, that you might actually get on the computer there at AU or the iPad or whatever and looked it up?
A. Maybe once a month.
Q. Okay. And what would cause that?
A. To verify an issue that I needed to clarify with a patient, and it was -- 90 -- in fact, all the times I went and referenced it, it was all due to skin issues.
Q. Back in 2011, there were -- there was a lot in the news even then about concussions, isn't that right? Kind of a hot topic?
A. I don't recall. At that time I was spending a lot of time doing my fellowship.
Q. Football fan?
A. Large football fan.
Q. Watch professional football?
A. I watch all kinds of football, sir.

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Q. College, professional? AU have a football team?
A. No.
Q. I didn't think so. Well, were you aware that at that time there were issues being raised about the relationship between concussions and -- and subsequent injuries?
A. Yes.
Q. Okay. Prior to your going to AU, were you aware of this -- this issue of concussions and subsequent injuries?
A. Yes.
Q. Okay. And how did you become aware of that?
A. Through my work through the military.
Q. Okay.
A. I saw a lot of concussions in the military, especially when I was deployed. I became very familiar with recognizing, diagnosing and treating them.
Q. I looked at your CV quick, and I don't

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-- I don't mean by this, Doctor, but it appeared to me that you were always in the United States --
A. No.
Q. Tell me where else you were.
A. I was stationed in Germany for three years, and while I was stationed in Germany I deployed to Romania and to Iraq.
Q. And what was the last one?
A. Iraq.
Q. You were never in Afghanistan?
A. No.
Q. You were in Iraq?
A. Yes.
Q. How long were you in Iraq?
A. I was in there for nine months.
Q. And where were you stationed?
A. I was in Miraz.
Q. In where, I'm sorry -- where?
A. I was stationed at -- hang on a second. Up at, it's called -- Miraz is up in the northeast corner of Iraq.

EXHIBIT

5

UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES
4301 JONES BRIDGE ROAD
BETHESDA, MARYLAND 20814-4712
http://www.usuhs.mil

NATIONAL CAPITAL CONSORTIUM
Graduate Medical Education

Agreement Number: NCC.10.063

MEMORANDUM OF UNDERSTANDING
BETWEEN
THE MEDICAL PRACTICE OF DAVID L. HIGGINS, M.D.
AND
THE NATIONAL CAPITAL CONSORTIUM

BACKGROUND

1. The National Capital Consortium (the Consortium) is an organization that provides unified and central management and administration for graduate medical education programs (i.e., internships, residencies, and fellowships) that are based at National Naval Medical Center, Walter Reed Army Medical Center, Malcolm Grow U.S. Air Force Medical Center, and the Uniformed Services University of the Health Sciences. It is an agency of the Department of Defense and is an instrumentality of the United States Government. For purposes of this agreement, all references to the Consortium shall include by implication the United States and all its instrumentalities.

2. This agreement is entered into, by and between the Consortium and the Medical Practice of David L. Higgins, M.D. (the Practice), located in Olney, Maryland.

3. The Consortium has established a family medicine/sports medicine fellowship program that has been accredited by the Accreditation Council for Graduate Medical Education. The program curriculum requires special clinical training in preparation for board certification of fellows, henceforth referred to as "trainees" in sports medicine. Trainees who will be trained under this agreement must be either physicians on active duty in the United States military (i.e., Army, Navy, and Air Force) or civilian physicians who are full-time employees of the United States government.

4. It is in the best interest of the Consortium for trainees to use the facilities of the Practice to receive clinical experience. This includes but is not limited to, experience obtained through clinical work performed specifically at American University and Good Counsel High School. It is to the benefit of the Practice to receive and use the clinical experience and performance of Consortium trainees.

GENERAL

5. While training at the Practice, trainees will be under the supervision of Practice officials for training purposes and will be subject to, and be required to abide by, all applicable Practice rules and regulations.

6. It is understood and agreed that there will be no training expense incurred by the Consortium as a result of this agreement.

7. This program will not result in the displacement of, nor is the program intended to displace, any employees of the Practice. Neither will the program result in the impairment of, nor is it meant to impair, existing contracts for services.

8. A Program Letter of Agreement (PLA) outlining specific goals and requirements for this clinical rotation will be executed between the director of the Consortium's Family Medicine/Sports Medicine Fellowship Program and the Practice's clinical point of contact. The PLA will include a basic outline of the anticipated training, training and supervision standards to be employed, and any other issues required by the Family Medicine/Sports Medicine Fellowship Program Review Committee.

9. The Practice reserves the right to refuse to accept or to bar a trainee from training when it is determined that their further participation would not be in the Practice's best interest.

10. The parties agree that trainees will be considered providers or members of the Practice's workforce while performing duties pursuant to this agreement, and so do not meet the definition of a business associate under the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d ("HIPAA"). No business associate agreement between the parties, therefore, is necessary.

11. It is understood and agreed that the Practice may generate professional bills for services rendered by Consortium trainees except for services rendered to patients who are beneficiaries of the Department of Defense/TriCare. Because Consortium residents, while training at the Practice, will be under the exclusive control and supervision of the Practice or its designated medical officials, proceeds from these professional bills will become the Practice's exclusive property and the Consortium will have no right or claim to such proceeds.

12. Neither party will use the name of the other party in any of its publicity or advertising media. The existence and scope of the program, however, may be made known to trainees.

13. It is expressly agreed that this written statement embodies the entire agreement of the parties regarding this affiliation, and that no other agreements exist between the parties except as herein expressly set forth. Any changes or modifications to this agreement must be in writing and must be signed by both parties.

14. The parties agree that they will abide by all requirements of the Accreditation Council for Graduate Medical Education and of the Family Medicine/Sports Medicine Fellowship Program Review Committee, including, but not limited to, those involving the supervision of trainees, trainees' work hours, and trainees' work environment.

15. There shall be no monetary obligation on the part of the Practice or the Consortium one

to the other. The parties intend that the Practice will provide training to be given on a non-reimbursable basis to Consortium trainees with the Practice.

16. The terms of this agreement will commence as of the date signed by both parties and will continue for a period not to exceed 5 years from this date. Termination by either party before that date will require written notification be sent thirty (30) days prior to the termination date. It is understood that the chairperson of the Consortium and the chief executive officer of the Practice will have the right to terminate the agreement without such required notice at any time, if such termination is determined to be necessary in the interests of mission requirements of their respective organizations.

RESPONSIBILITIES OF THE PRACTICE

17. The Practice will make reasonably available the facilities needed for training and, to the extent possible, will treat trainees as if they were members of the Practice's permanent staff.

18. The Practice will arrange schedules that will not conflict with trainees' other educational programs.

19. The Practice will agree to coordinate Consortium trainees' clinical experience. Such coordination will involve planning with the Consortium for trainees' assignment to specific projects and experiences, including attendance at selected clinics, conferences, courses, and programs conducted under the direction of the Practice.

20. The Practice will provide Consortium trainees reasonable working and storage space.

21. The Practice will grant Consortium trainees administrative privileges typically enjoyed by its professional staff.

22. The Practice will permit, on reasonable request, the inspection of clinical and related facilities by the government agencies or other agencies charged with the responsibility for accreditation of Consortium education programs. To facilitate such inspection, the Practice has executed the attached HIPAA Business Associate Agreement (BAA) with the Accreditation Council for Graduate Medical Education. This BAA authorizes the Accreditation Council for Graduate Medical Education to access medical information from the Practice's records and files solely for purposes of accreditation review.

23. The Practice will notify the Consortium as soon as possible, but no later than within three business days, in the event a trainee is involved in any professional or behavioral problems that raise concerns about his or her ability to continue training with Practice physicians.

24. The Practice will provide trainees emergency medical and dental treatment to every extent possible while they are at the Practice for training. The Practice will be reimbursed for the cost of such treatment.

RESPONSIBILITIES OF THE CONSORTIUM

25. The Consortium will have its faculty or staff members coordinate with Practice physicians the assignment trainees will assume and their attendance at selected clinics, conferences, courses, and programs conducted under the direction of the Practice.

26. The Consortium will provide and maintain accurate personnel records and reports developed during the course of trainees' clinical experience.

27. The Consortium will ensure compliance with all applicable Practice rules and instructions and those of its physicians.

28. The Consortium will educate trainees on the protection and privacy of protected health information and will provide evidence of such training to the Practice upon request. Such training will meet the requirements of HIPAA and its privacy rules and of DoD 6025.18, *DoD Health Information Privacy Regulation, dated 24 January 2003.*

29. The Consortium will be responsible for health examinations and such other medical examinations and protective measures necessary for trainees.

30. The Consortium will prohibit trainees, faculty and staff members from publishing any materials developed as a result of trainees' training experience with the Practice without the prior express written consent of the Practice, the appropriate Practice officials, and the Consortium.

LIABILITY

31. The Practice will provide professional liability (malpractice) insurance, in amounts that are reasonable and customary in the community for the appropriate specialty, covering liability for personal injury or property damage, including legal representation and expense of defense of any such liability claims, actions, or litigation resulting from consortium trainees' participation under this agreement. This coverage may come from any source, but clearly shall cover Consortium trainees while they are participating in training at Practice facilities. The Practice agrees that, if it intends to change such liability coverage during the tenure of this agreement in a way that will affect the protection provided Consortium trainees, then it will notify the Consortium in writing at least forty-five (45) days prior to the effective date of the change, specifying the changes intended to be made. The Practice must provide documentary proof of the insurance coverage to the Consortium. The Practice further agrees not to seek indemnification from the United States, the Consortium, or Consortium trainees for any settlements, verdict, or judgment resulting from any claim or lawsuit arising from Consortium trainees' performance of their professional duties while acting under the control of the Practice or the control of Practice employees.

32. While assigned to the Practice and while performing services pursuant to this agreement, Consortium trainees remain employees of the United States performing duties within the course and scope of their federal employment. Consequently, secondary liability coverage is provided under the provisions of the Federal Tort Claims Act (Title 28, U.S.C. § 1346(b), 2671—2680), including its defense and immunities, and will apply to allegations of negligence or wrongful acts or omissions by trainees while acting within the scope of their duties pursuant to this memorandum of understanding.

POINTS OF CONTACT

33. For The Practice:

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34. For the Consortium:

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APPROVALS AND ACCEPTANCES

FOR THE NATIONAL CAPITAL CONSORTIUM

LARRY W. LAUGHLIN, M.D., PH.D.
CHAIRMAN, BOARD OF DIRECTORS

DATE

FOR THE MEDICAL PRACTICE OF
DAVID L. HIGGINS, M.D.

DAVID L. HIGGINS, M.D.

11-7-10
DATE

EXHIBIT

6

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF COLUMBIA

JENNIFER BRADLEY

Plaintiff

vs. Case No.:

AMERICAN UNIVERSITY, et al. 1:16-cv-00346-RBW

Defendants

_____/

The video-recorded deposition of DAVID HIGGINS, M.D., was held on Monday, October 16, 2017, commencing at 1:59 p.m., at the Law Offices of Paulson and Nace, PLLC, 1025 Thomas Jefferson Street NW, Suite 810, Washington, DC 20009, before Alvin Ecarma, Notary Public.

REPORTED BY: Alvin Ecarma

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Q. Is there someone who would know better than you?
A. No.
Q. Okay.
A. Hopefully not.
Q. Looking at that I see that your office is out in Olney; is that correct?
A. Yes, sir. In Olney, Maryland. Yes, sir.
Q. And you graduated from Georgetown School of Medicine in 1984, right?
A. Yes, sir.
Q. Looking at what you've done since then, it appears that you did a fellowship -- did your residency at Baylor, and then you did a fellowship in sports medicine in 1990 and 1991; is that correct?
A. Yes, sir.
Q. Was that the last time you had any formal education?
A. We have conferences we go to every year, but yes.
Q. So do we.

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A. Okay. All right. Sorry.
Q. Other than --
A. Oh, sorry. For another degree? No, sir.
Q. No other fellowships, no other residencies or anything like that?
A. No, sir.
Q. Okay. And yours was -- your fellowship was in sports medicine, but your residency was in orthopedic surgery, is that right?
A. Yes, sir.
Q. When did you actually start to practice medicine in this area?
A. 1991.
Q. And why did you come to this area?
A. The navy sent me here first.
Q. To where?
A. To the naval hospital in Bethesda.
Q. Where were you born?
A. Memphis, Tennessee.
Q. Okay. So you're not from this area originally?

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A. No, sir.
Q. Okay. So you came in here about 1991 to Bethesda Naval.
A. Yes, sir.
Q. And how long did you stay there?
A. Three years.
Q. And once you finished that, where did you go to?
A. To a practice in Olney. A group practice.
Q. Okay. And what was the name of that practice?
A. Potomac Valley Orthopedics.
Q. Okay. So from that point on, have you always been in practice in the Olney area?
A. Yes, sir.
Q. All right.
A. Sorry. In Rockville. At Olney for two years, Rockville for three or four years I think after that, and then back to Olney.
Q. Okay. When did you start practicing what is referred to as sports medicine?

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A. From the time I finished my fellowship.
Q. Okay. What does that mean? Sports medicine?
A. Taking -- just taking care of athletic injuries of all kinds.
Q. There's not a board-certification for that, is there?
A. It's a certificate of added qualifications, correct.
Q. And I saw that on here somewhere in your CV. How do you get that?
A. Further -- you have to have further training, number 1, to be able to sit for the exam, and then there's a separate exam for that.
Q. Well, you got your fellowship in '91.
A. Yes, sir.
Q. And you got this added qualification 13 years -- more than the nine -- some 16 years later or so?
A. Yes, sir. Because they didn't have that up until then.

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Q. Yeah. What is that?
A. It's the -- I guess the conglomerate of the fellowship so that --
Q. I don't understand what that means. "Conglomerate of the fellowship."
A. Well, I guess -- I guess unifying all of the -- all of the fellowship physicians together to teach the sports medicine fellows.
Q. So you entered into this agreement with this consortium?
A. Yes, sir.
Q. And what -- we have the document. What did you understand your duties were pursuant to that agreement?
MR. ARMSTRONG: Object to the form of the question, but you can answer.
A. It's a -- to help teach the fellows orthopedic sports medicine.
Q. Okay. And did you get paid for doing that?
A. No, sir.

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Q. Okay. So am I correct in that the consortium would be the ones who would interview and decide who was going to get the fellowship?
A. Yes, sir.
Q. And then they give them to you?
A. Yes, sir.
Q. Let me have that back. It says here that "the consortium is an organization that provides you unified and central management administration for graduate medical education programs, i.e. internships, residencies, and fellowships that are based at National Naval Medical Center, Walter Reed, Malcolm Grow, and the Uniformed Services University of Health Science." All right. So this is something that this consortium, this thing, would place, I take it, these fellows in these various institutions; they could place them at Malcolm Grow, they could place them at Walter Reed --
A. They weren't all based individually at those places. They had different responsibilities.
Q. Okay. But the way you got this particular

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-- in this case Mr. -- Dr. Williams was through this consortium?
A. Yes, sir.
Q. All right. You said that they didn't pay you anything?
A. Correct.
Q. Do you know if they were paying him anything?
A. I don't know anything about the pay. No, sir.
Q. Did you pay him anything?
A. No, sir.
Q. He pay you anything?
A. No, sir. No, sir.
Q. Did anybody pay anybody anything?
A. Not just --
Q. To your knowledge? To your knowledge --
MR. ARMSTRONG: Wait -- just -- just wait for him --
THE WITNESS: Sorry.
MR. ARMSTRONG: That's a facetious

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question.
A. Okay. I don't know.
Q. Okay.
MR. NACE: Let's mark this as 4.
(Plaintiff's Exhibit 4, Contract, marked for purposes of identification.)
Q. I'm going to show you what we've marked as Exhibit 4. It says, "Professional Services Agreement - Medical Malpractice." Can you tell us what that is?
A. It's a contract that I have with American University.
Q. All right. So this is the document -- it's signed August 15th, 2011 -- at least it's dated that -- that you had to provide services to AU, to the students involved in their athletic programs, correct?
A. Yes, sir.
Q. And you did get paid for that, didn't you? As part of the contract terms, right? You got something for doing that?

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A. I think we're all different. So yes, they provide health care for the athletes but as an athletic trainer.
Q. Okay. Well obviously they're not a nurse, they're not a --
A. Right.
Q. -- laboratory technician --
A. That's right.
Q. -- but they're health care providers too, aren't they?
A. Under the present political system, yes.
Q. But you don't think they are really? In your mind?
A. I think they're all different, yes, sir.
Q. When you say they're all different, I don't know what you mean.
A. Because I like to call somebody by who they are. If you're a nurse or a athletic trainer or physician, etc., or physical therapist. I guess I don't like lumping everybody together.
Q. Well, who would you say is a health care

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provider? I'm just trying to understand what you're saying. Just so I follow.
MR. ARMSTRONG: At this point, I think he's answered the question and I think you're just being argumentative.
MR. NACE: I'm not at all.
MR. ARMSTRONG: Yes, you are.
Q. I don't know what you mean.
A. Everybody provides their own piece to the puzzle, to the patient. It's just I don't like grouping them all together under that. Everybody has got their own area of expertise.
Q. I understand. What I'm saying in your view --
A. Right.
Q. -- just in your view --
A. Right.
Q. -- you think it might be different?
A. But in my view, that's what I think. I mean, they're all providing care to the patient. I just don't like lumping everybody as a health care

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provider.
Q. Okay.
A. Because they've all got their area of expertise.
Q. Okay. And you don't know what a health care provider is under the law; is that what you're saying?
A. No, I didn't say that.
Q. It's not your area. You don't know.
A. Well, I didn't say that because -- but I don't know the law.
Q. Okay.
A. I don't know what the legal definition of health care provider is.
Q. Would you consider a nurse to be health care?
A. Yes, sir. Yeah.
Q. Okay.
A. All right.
Q. Did you then consider trainers to be health care providers?

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MR. MURPHY: Objection.
A. I considered them to provide care to the patient, to the athletes.
Q. Okay.
A. And I don't mean to get argumentative either.
Q. I'm not trying to be argumentative with you. I don't think you're trying to be argumentative with me. That's --
A. Sorry.
Q. That's not the point.
A. Okay. Yes, sir.
Q. All right. Doctor, did you ever see Jennifer Bradley?
A. No, sir. I don't have any recollection of seeing her.
Q. Do you recall ever talking about her with anyone?
A. No, sir.
Q. Other than your attorney?
A. No, sir.

EXHIBIT

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Volume:
Pages: 139
Exhibits: 0

COMMONWEALTH OF MASSACHUSETTS

JENNIFER BRADLEY,)
)
Plaintiff,)
)
vs.) No. 1:16-CV000346
)
NATIONAL COLLEGIATE)
ATHLETIC ASSOCIATION, et)
al.,)
)
Defendants.)
)
)

DEPOSITION OF ROBERT CANTU, M.D.

This deposition taken pursuant to notice at the offices of Robert Cantu, M.D., 131 Old Road to 9 Acre Corner, Concord, Massachusetts, on Wednesday, June 6, 2018, commencing at 1:09 p.m.

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Also Present: Mr. Barry J. Nace (Via Zoom)

Court Reporter:

Molly K. Belshaw
RPR, Notary No. 2045133

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NO. DESCRIPTION	PAGE

(No exhibits were entered.)

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ROBERT CANTU, M.D.
having been duly sworn by Ms. Belshaw,
was deposed and testified as follows:
EXAMINATION
BY MR. MURPHY:
Q. Can you please state your full name for the record?
A. Robert Clark Cantu.
Q. Doctor, I know you've had depositions taken a number of times. My name's John Murphy. I represent American University in this case.
Because we are doing this via video, it's going to be very important that only one of us talks at a time. It doesn't sound like or look like there's a delay, but if by accident I cut you off before you give an answer to one of my questions, please put up your hand or stop me so that I can stop and let you give a complete answer to my question; okay?
A. Yes.
Q. If you don't understand any of my questions, please let me know so that I can rephrase. And if you answer my question, I'm going to assume you've understood it; fair enough?
A. Yes.

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Q. If you need to take a break at any time, just let me know. If you have any other questions as this issue proceeds, let me know that as well; okay?
A. Thank you.
Q. Great.
What did you bring with you in preparation for today's deposition?
A. I brought the three binders, which are the entire medical record that I have on Jennifer Bradley.
Q. I know you prepared a report in that case. And in that report, you listed the records that you've reviewed.
Is that what's contained within the three binders?
A. Yes.
Q. Have you been provided any additional materials since you prepared your report that you have reviewed in preparation for today?
A. Yes.
Q. What have you reviewed since the report was prepared?
A. Today I received the three reports of the experts designated by the defendants. That

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would be the report of Cynthia Monroe, Kevin Crutchfield, and Gary Ho.
Q. Anything else that you have reviewed since you prepared your report?
A. I don't think so. Nothing that I remember.
Q. There was an expert report by a certified athletic trainer by the name Tori Flanley (phonetic).
Did you review that, by any chance?
A. No, I don't believe I did. But there was also a report prepared by Joseph Kraus in January 2018. I'm not -- I'd have to see when my report was prepared. That may have been received after my report as well.
Q. Okay. And, then, Counsel was kind enough to fax to me essentially what is a one-page, handwritten note at a very sharp angle.
Are these handwritten notes that you prepared in reviewing some of the records in this case?
A. Yes. I made some notes on some of the depositions, correct.
Q. Okay. Other than the handwritten notes and the report that we were just referencing a minute ago, have you prepared any other notations,

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reports, things of that nature?
A. Well, there are some things that are highlighted, but nothing that is, to my knowledge, any other handwritten notes.
Q. In other words, you may have highlighted something in the depositions or something in the records --
A. Correct.
Q. -- but you did not prepare any type of timeline or chronology of the medical treatment Karen had?
A. No.
Well, that is, other than is in the factual background.
Q. Right. I have your report.
I'm just saying you don't have, like, handwritten notes of the timelines as you were going through the medical records, do you?
A. No, sir. No.
Q. Doctor, I had a chance to review your CV. And I don't want to go through it line by line, but can you just kind of give me a sense, in sort of a week, what type of things you do? Because I know you have a lot of different responsibilities and hats that you wear.

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A. My workweek is comprised of 24/7 being responsible to be available to the Concussion Center that bears my name, employs six clinicians and over 35 therapists. I spend two days a week there.

The rest of the time, I'm just available by phone or e-mail. I spend one day a week in my office seeing neurosurgery patients, and do a small number of outpatient neurosurgery procedures. But I no longer do any lengthier intracranial or spinal procedures, or any inpatient neurosurgery operations.

We're involved with the center for the study of traumatic encephalopathy at BU, and every week that either involves conference calls, or e-mail exchange, or sometimes me actually having to go there.

More weeks than not I'm traveling, whenever possible, one day a week, to be out and back the same day, to give a talk -- usually, on traumatic brain injury, concussion, or CTE.

And in addition to that, we reserve roughly one day a week, although it varies from week to week, and some weeks it's certainly

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none, to do matters similar to what we're involved with today.

Q. When you state, "Matters similar to what we're involved with today," you're referring to being an expert witness in litigation cases?

A. Yes. And I -- arbitrarily, I say one day a week. And we don't work five days a week, so it's not really 20 percent of my time.

But if we want to just use a five-day week, that's fine with me, to say roughly 20 percent. And the rest of my time is spent with consulting to a number of different organizations -- the NFL, the National Operating Committee on Standards for Athletic Equipment, the Center for the Study of Traumatic Encephalopathy, the National Center for Catastrophic Sports Injury Research, et cetera.

Q. When do you do academic writing? Or are you no longer doing that?

A. No, I'm very involved with that. Fortunately for me, that's every week we're involved -- almost every week with some of that. Some weeks, an awful lot.

Fortunately for me, now a great deal of

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that is being done by young post-docs and grad students at Boston University. So it's more editing, and that kind of thing. But there are multiple publications this year that we've already done, alone, without anybody else, although the majority of the publications have involved multiple other people.

Q. I noticed on your CV you also have a number of teaching employments.

Are you still involved in teaching?

A. Yes.

Q. And where does that fit into the schedule?

A. It fits in in that one day a week, roughly, we're off lecturing somewhere where -- that could be local. It could be, more often than not, not local.

Q. And I saw -- I think you were adjunct professor down in North Carolina.

How often are you down there?

A. Very little right now. It's almost all done exclusively by conference calls, e-mails. There was a time when I was physically involved giving a course there over a period of Mondays, but I'm not currently, actively giving a course there.

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Q. Okay. Are you actively teaching courses anywhere at the time?

A. Well, every week I'm somewhere lecturing as part of a course -- almost every week. And we're a part of a course, for instance, coming up with the American Academy of Neurology. In July, we'll be doing a course in Indianapolis we've just gotten back from doing a course for New York University and the Mayo Clinic in Arizona. So these meetings that I lecture at are almost always a two or three-day course.

Q. Okay. How often are you involved in treating student athletes that are suffering from concussion or concussion-like symptoms?

A. Every week.

Q. Is that part of your day of seeing patients at your office?

A. No. It's more a part of my two-day seeing patients at the Concussion Center.

Q. Got it. Okay.

And I guess what I'm trying to figure out is how much of that patient population is student athletes, as opposed to professional athletes, as opposed to other people who may have concussions or other neurological

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injuries?
A. Yeah. I've never broken it out exactly. We do have at our Concussion Center a pediatric neurologist that's part of our three-neurology team. We have three nurse practitioners and three neurologists, counting myself as a neurologist/neurosurgeon.
And so because he's there seeing exclusively kids, I don't see as many kids as I once did. But we still do see kids every week.
Q. And how are you defining, "Kids?" What age group?
A. Yes. 18 and under.
Q. Your report that you have prepared in this case -- I think I'm starting on page five.
You go through a listing of qualifications, which I assume is sort of a highlight of your curriculum vitae; is that correct?
A. Well, it's selected from it, yes.
Q. Right.
And if you could just kind of go through with me and highlight for me your experience as it relates to athletic trainers, because I'm representing American University in this case,

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and I just want to focus in on that experience you have at the moment.
A. Well, many of the meetings that we're involved with -- sports medicine meetings, athletic trainers are present at the meetings.
I also have lectured a number of times at the annual meeting of the National Athletic Trainers' Association, and have an award from there -- an emeritus award, because of the contributions we've made.
So my involvement with athletic trainers, besides having one in the center, is primarily at the lectures that I give at the various meetings.
For instance, the two meetings I just cited, the American Academy of Neurology -- I mean, there will be physicians at that meeting, but there will also be a number of athletic trainers, as was true of the meeting in Arizona that the Mayo Clinic and New York University jointly sponsored.
So because certified athletic trainers are a significant component of the treatment team, especially at the college level -- but also, fortunately, at most high schools in this

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country, they attend and need to receive education on a variety of topics -- one of them being traumatic brain injury and concussion.
Q. You mentioned a moment ago -- do you have an athletic trainer on your staff at one of your positions?
A. We do.
Q. And tell me about that.
What position is that?
A. He functions in more -- the center is primarily clinical, without question, with several thousand visits a year.
But we also do have research grants, and we do research studies. And he's involved with one of those research studies, and he's also involved a bit with outreach to area schools in an educational way.
Q. But that athletic trainer, that's not someone that provides hands-on patient care, if you will, that you oversee; is that correct?
A. Not in the direct sense that an ocular therapist would be giving ocular therapy to patients, or a cognitive therapist would be giving cognitive therapy. He does -- he is responsible for one or more of our exercise

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programs that are run through the center. And in that sense, he is providing some supervision of using exercise equipment.
But you're absolutely right, he's not providing specific therapy quite like other therapists would be doing in their own special areas.
Q. Putting aside your lecturing of athletic trainers, in your experience, have you ever worked for a team, a university? Anything like that where you were part of the overall athletics that included athletic trainers?
A. Many years ago, we were a team physician for local high schools that had athletic trainers. We were team physician for the football team. We've also served as a consultant for Boston College football team and for some local pro teams.
Q. Well, you say, "Some time ago."
Ballpark, how far back was that, Doctor?
A. In terms of being on the field -- sideline care of athletes that we did as a football team physician, probably not in the last 15 years -- maybe ten, probably 15. I'm not sure.
Q. All right. Anything else that comes to mind

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with your background, training, and experience as it relates to athletic trainers?

You told me about the lecturing you do, your work with the NATA. You told me about the athletic trainer who's on staff at your concussion center -- your concussion clinic. And you told me a couple consults that you've done with local football teams. I think you said high school, college, and professional level.

Anything else in your background specific to athletic trainers?

A. The work that we did as an adjunct professor for the Department of Exercise and Sports Science at University of North Carolina, those are primarily PhD athletic trainers in that program.

So through the years, I've been involved with a number of athletic trainers/PhDs as -- they have on their PhD committee as they've gone and gotten their doctorate, as I have been with individuals going for a PhD at Boston University.

Q. Okay. I know that you were involved in the NATA position statements on concussion

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protocol.

How did you get involved in that?

A. We got involved because we got asked to be a part of it, but that was the period of time when we were very involved with the Department of Exercise in Sports Science at UNC.

The chair of that committee I believe at that time -- or the department at that time was Kev Guskiewicz. I think he was the lead author on that committee. And when he put that committee together, he invited me and others that had a lot of activity in the concussion area to be on the committee.

I had also been a member -- a founding member of the Concussion in Sport international committee, and that probably was a bit of an entree as well.

Q. Other than the 2004 and 2014 NATA concussion position statements that you were a part of, do you have any other publications specific to athletic trainers with regard to concussion management?

A. Not specific, but the majority of our more than 430 current publications are about traumatic brain injury, concussion and/or the effects of

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repetitive brain injury -- cognitive, behavioral, and mood difficulties, including the condition of CTE, but not limited to it.

And virtually all of those publications about athletes and the condition in athletes are directed, in part, at athletic trainers, as that information is very relevant to them in their careers.

Q. But are any of them -- show up in publications that athletic trainers are going to be reviewing on a regular basis?

A. I've written -- yes, is the answer to that.

I've written in a variety of journals that athletic trainers would be expected to read, including the Journal of Athletic Training.

Q. I'm sorry. The Journal of...

A. Journal of Athletic Training.

Q. Got it. And so that's what I was trying to figure out.

So I know about the two position statements. Do you have other articles that you've written in the Journal of Athletic Training?

A. I believe so. I'd have to look through my CV, but I'm virtually positive that we've written

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articles in the Journal of Athletic Training, and we've also written articles in Medicine & Science in Sports & Exercise for the American College of Sports Medicine that athletic trainers tend to read, as well as other journals that they read.

Q. How did you first get involved in doing work for litigation cases?

A. I first got involved by patients asking me to be involved in their own cases. And that would go back more than 30 years ago.

And then I next got involved primarily by helmet manufacturers asking me to be involved in defending some of their cases a number of years ago. And then from there, it just -- I guess kind of word of mouth or something.

And I didn't seek it out. It just kind of came my way. And if I thought it was something that I could -- that was in my wheelhouse of expertise and I wanted to do it, then I would agree to do it.

Otherwise, there are many, many cases through the years that we will refuse to be a part of, because we don't believe they're meritorious.

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Q. And the list that I have of your expert testimony goes back to 2014. But you've just told me you've been doing expert work much longer than that; correct?
A. Correct.
Q. Can you give me a sense as to how many cases you review on an annual basis now, and how that -- just in general, how that's changed over the years?
A. Well, it has changed because we got involved essentially testifying on behalf of our own patients, which is, of course, Plaintiff's side. Then we got involved a little bit with regard to defense work for product liability.
And then out of that or whatever seemed to come some med mal work. And the med mal work, in the beginning, was primarily on the plaintiff's side, although in recent years it's shifted more toward -- it doesn't equal 50/50, but it certainly shifted more toward the defense than it ever was before.
Q. So currently, ballpark, how many or what percentage of your med mal work do you think is on behalf of defendants?
A. I really don't know, because I've never counted

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it. It may be 30-ish percent.
Q. And about how many cases a year are you looking at these days?
A. It would vary within the year. And some of the cases we look at are including cases that we refuse to be a part of, although the overwhelming majority of cases that we refuse to be a part of are things that we decline participation in after an e-mail synopsis and a phone call.
I would say somewhere above ten, and it's certainly under 20. And it varies from year to year, but probably in that ten to 15 category. It doesn't feel like one a month, so maybe that's even a little high.
Q. Do you know how Plaintiff's counsel found you in this case?
A. I have no idea.
Q. Have you ever worked with Plaintiff Counsel's law firm prior to this case?
A. I don't know, is the answer. I'm not aware of it. It could be.
Q. Do you know how much time you've spent so far on this case?
A. No, but my office manager keeps track of that,

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and she can provide a precise number.
Q. Will that include the invoicing that you've issued, to date, for time on this case?
A. Yes.
Q. Okay. Great.
I don't need you to create something, but do you typically invoice on, I don't know, 30 days? Or what's your invoicing practice?
A. Once a month.
Q. Okay. So there should be invoices generated for this case by now; correct?
A. Yes.
Q. If you could just make sure you get those to Counsel so he could produce them, that would be terrific.
A. Well, if you put it the other way around -- get it to -- have Counsel request if from Sharon, we'll definitely get it to you at the end of this deposition. I don't want to remember how many things you asked me to produce.
Q. All right.
Doctor, on the case list that you have provided, it just has a case name and, I believe, the year.
Looking at the list, can you say which of

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those cases were for the plaintiff or defense, or what the issues were in any of those cases?
A. In almost every instance, no.
Q. To your knowledge, have you ever been an expert in a case involving a field hockey student or college athlete?
A. I don't know. I just can't be certain. I can't imagine I haven't, but I also don't remember, specifically.
Q. Have you ever testified in a case that a plaintiff did not sustain a concussion?
MR. NACE: Objection.
THE WITNESS: I'm not trying to avoid the answer. There have been cases that have involved subdural hematomas and an intracranial hemorrhage, and concussion wasn't the issue.
So, sure, there have been a number of cases where concussion wasn't something that I diagnosed.
Q. (By Mr. Murphy) And thank you for that, Doctor. It was a terrible question on my part, which is probably why Counsel objected.
In the concussion cases that you have handled where there was an allegation of there being a concussion, I know you told me a little

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while ago that you have done some defense work.
So what I'm trying to figure out is, have you ever reviewed one of those cases and found that there was no concussion, as opposed to finding that there was a concussion but the healthcare provider complied with standard of care diagnosis?
A. I'm pretty sure there have been cases where I've felt there hasn't been concussion, but they've almost -- all the cases I can think of are cases where I've been asked to be a part of the plaintiff's side and, therefore, declined. So they're not cases that I ultimately became a part of.
Q. Have you ever not qualified as an expert in court, or had the scope of your qualifications limited by a court?
A. No. Not to my knowledge.
Q. Have you ever testified on behalf of an athletic trainer?
A. The answer is I don't remember. I'm not certain, but I don't sit here and immediately have a case that I can recall. But I can't recall very much of the cases, either.
Q. And I understand that, and that's fair, Doctor.

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I'm just asking you for your best recollection at this time. I'm going to ask you the converse.
Can you recall testifying against an athletic trainer, as opposed to, you know, another type of physician?
A. There have been plaintiff cases that I've been involved with that have involved physicians, of course. And kind of indirectly, I've testified against the athletic trainer as part of the medical team in some instances.
But I'm not an athletic trainer, so I don't hold myself out to be a standard of care expert for athletic trainers.
Q. Okay.
I want to ask you some general concussion-type questions, and then we'll get into the specifics of this case. For the purposes of what I'm going to ask you now, this next line of questions, I want you to assume that I'm talking the 2011 time frame. That's what we're ultimately going to be dealing with.
I know that concussion protocols have changed over the years, but that's why I'm limiting it to 2011. If you need to clarify or

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modify any of your answers, please just let me know as we go through this section; okay?
A. Yes.
Q. And the general proposition, Doctor -- would you agree that managing sports-related concussions is one of the more complex challenges for a sports medicine doctor?
MR. NACE: Objection.
THE WITNESS: Well, it can at times be challenging, yes.
Q. (By Mr. Murphy) Generally speaking, when is an athletic trainer required to get a physician involved in a case with a suspected concussion?
A. That depends on the working relationship that the athletic trainer has with the physician they're working with, or physicians they're working with. In some situations, the physicians want all concussions to come to them through the athletic trainer.
And in other situations, not always does the physician necessarily want to see the concussion patient, although the majority will say they would like to see them at some point along the line before Return to Play is initiated.

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Q. So if I'm following you correctly, a physician may not be required at the outset, but before Return to Play decision's made, the physician should get involved.
Is that -- am I paraphrasing you correctly?
A. Generally speaking, yes. Correct.
Q. Okay. Have you -- I thought you were going to give me a little different answer, based on the NATA position.
What is your position as to when a physician should get involved with a student athlete suspected of a concussion?
A. Well, ideally, I think a physician should be involved with every student athlete that is diagnosed with a concussion or a concussion cannot be absolutely concluded. So if there's a diagnosis of concussion or there's doubt about whether there's a concussion, then, in my opinion, physician involvement should occur.
Q. Back in the 2011 time frame, do you have a sense as to what percentage of NCAA Division I schools were actually having physicians involved in cases of a suspected concussion?
A. I don't have a precise answer to that, because

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I've never seen a survey published of that. But it's obvious that at many schools, the physician involved -- physician responsible was not seeing the patient.

In this particular case here, I realize that it was Dr. Williams that actually saw the patient. But Dr. Higgins, who's ultimately the team physician for this university, said he'd seen one concussion.

"And by the way, I'm an orthopedist, and I wouldn't treat him, anyway." Well, that's suggesting that certainly not a high percentage were going in his direction.

Q. I will -- I don't want to tread on counsel for Dr. Higgins, so I'll let him ask follow-up questions on that. I'm going to stick to American University's training staff for now, Doctor.

A. Yes, sir.

Q. What is your understanding as to athletic trainers' responsibility to follow physician orders?

A. They are responsible for following physician orders, and they're responsible for following protocol that the university has agreed is the

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way they're going to handle certain situations.

Like, the NCAA has a requirement from 2010 going forward. Therefore, that included 2011. And American University correctly followed that protocol and had a concussion management protocol, and I would expect the athletic trainer would follow that protocol.

Q. To your knowledge, are there any concussion management protocols that exist for what to do when a student athlete is not diagnosed with a concussion?

MR. NACE: Objection.

Matt Mace.

THE WITNESS: No, I'm not aware of protocols for that. We're all aware that a great number of concussions are missed on the athletic field. Depending upon whose research you want to cite, it could be as many as 50 percent or even higher of minor concussions. And so clearly, concussions that are not diagnosed -- there isn't a clear-cut protocol for following those.

For individuals that are being assessed for possible concussion, there are guidelines and recommendations that serial assessment

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might occur. But, basically, if one has seen an individual and excluded them from having a concussion, that serial follow up would not necessarily be routine.

Q. (By Mr. Murphy) What role does the student athlete have in timely reporting signs and symptoms of a concussion?

MR. NACE: Objection.

THE WITNESS: Well, it would be the hope that an athlete would be educated about what the signs and symptoms of concussion are. And it would be the hope that if the athlete had these symptoms, either acutely at the time of head trauma or, as is not uncommon with concussion, the symptoms were delayed in their onset, that the athlete would report them.

Unfortunately, that's not uniformly what happens, but it's happening to a greater degree now than it was ten years ago.

Q. (By Mr. Murphy) When the concussive symptoms persist, when do you typically try to get MRI or CT imaging to help with your diagnosis?

A. Well, MRI and CT imaging don't help with your diagnosis of concussion, so it's not done for that purpose. MRI and CT imaging with

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concussion is going to be normal because that's a macroscopic study, and concussion is both a metabolic injury and, in many cases, a microscopic structural injury. But you won't see it on MRI or CT.

So you get an MRI or CT when you're worried about some other life threatening process being present, like an intracranial bleed or some other process being there that's explaining the symptoms not clearing up.

Q. All right.

Doctor, let's switch gears a little bit. I want to talk about your understanding of the actual facts in this case; okay?

A. Yes, sir.

Q. Great. Let's start with the plaintiff's history prior to American University.

To your knowledge, did she ever sustain any concussions?

A. I don't think I have a detailed history that antedates American University. I'm not aware that she did. It could have happened.

Q. Is a history of concussions important in predicting how one is going to respond to future concussions?

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A. It is helpful, as are a knowledge of underlying conditions that may predispose one to a very prolonged concussion recovery such as ADD, ADHD, dyslexia, panic attacks, anxiety disorder, depression, migraine, seizure disorder, among others.
Q. And I'm not sure if I fully understood one of your prior answers, so I'll just ask it this way.
Do you have any medical records for this plaintiff that pre-date American University?
A. No. I did not receive records that pre-dated, and I did not exam this patient, so that I don't -- I didn't have the opportunity to get that information.
Q. Then let's jump to the 2011 field hockey season at American University.
What is your understanding as to what day or when she sustained an injury?
A. On September 23, 2011, she was playing a game -- a field hockey game and took a shoulder to the head. And subsequently, later that day noted difficulties with vision, difficulties with concentration, and difficulties with fatigue.

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Q. And are you looking at your report at the moment, Doctor?
A. Among other things, yes.
Q. So what I'm trying to -- or what I want to get a sense for is that history that you just provided me.
Where did you get that information from? Do you recall?
A. From the medical records.
Q. Well, she wasn't seen by anyone on the 23rd, so...
A. No, she was seen by people in October. Correct.
Q. You mention that subsequently, she reported those problems.
When did the plaintiff first report those signs and symptoms following the September 23 game?
A. Yeah. I don't have -- she was seen by the athletic trainer because of issues -- similar issues with vision, and fatigue, and concentration after a Boston College game that was played, I believe, in early October, and then was seen by the athletic trainer, who subsequently obtained within a period of two

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days three different SCAT studies -- SCAT2 studies. And then, following that, she subsequently was referred to Dr. Williams.
Q. And what is it that you're looking at at the moment, Doctor?
A. I'm looking primarily at my disclosures, though what's in my disclosures came directly from the medical records.
Q. Let me ask it this way to try and speed it along.
Well, first, did you see the actual SportsWare notes that the athletic training staff were making?
A. I read the deposition of the athletic trainer. I don't remember if I saw the actual -- today, I don't remember whether I saw the actual handwritten notes that she did, except that she put notes on the SCAT2 study that was done on October the 4th.
Q. I will represent to you that my understanding is, generally, the athletic trainer documented that she first was approached by the plaintiff after the field hockey game on October 2, and then that started the SCAT testing and referral to the physicians.

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Based on your understanding of what you've reviewed, do you have any information that the plaintiff reported signs and symptoms to anyone at American University prior to October 2?
A. I don't sit here and remember it, no.
Q. Do you have any understanding as to why, if the plaintiff began to develop vision problems, concentration problems, and dizziness problems on September 23, she did not report anything until October 2?
MR. NACE: Objection.
THE WITNESS: I can't be 100 percent certain, but the overwhelming reason most student athletes don't report symptoms, and certainly most female student athletes don't report symptoms, is they don't understand what they represent. They don't understand that there could be a concussion. They don't understand the importance and the possible ramifications of not being properly treated for those symptoms.
Q. (By Mr. Murphy) As part of your review of materials in this case, did you see any educational materials that were provided and signed for by the plaintiff regarding signs and

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symptoms of a concussion?
A. No, but I would be a little surprised if they're not there somewhere. But I don't remember it, as I sit here today.
Q. Okay. Do you, as you sit here today, have any idea how many games or practices the plaintiff participated in between the September 23 alleged injury and October 2, when she first reported it to Jen Earls?
MR. NACE: Objection.
THE WITNESS: I don't have a number, but I believe it's multiple.
Q. (By Mr. Murphy) What is your knowledge as to when the team physician, Dr. Williams, first saw the plaintiff?
A. He saw her, I believe -- well, I can look through the records and pull out his note. And also -- I guess I could get it from his deposition, too.
But he did not see her right away. He did see her after the three SCAT studies had been done, was my understanding -- and that he did not look at the SCAT studies that were done.
Q. Did you see any indication in the records or the deposition testimony that you reviewed that

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the plaintiff was referred to a neurologist?
MR. NACE: Objection.
THE WITNESS: I saw reference in the record that after Dr. Williams saw the patient and the patient continued to have symptoms, that he recommended that she see a neurologist. He did not, apparently, make an appointment for her to see a neurologist, and at that time she didn't. She was seen ultimately by an emergency department doctor. She was seen subsequently by an ENT physician.
But it wasn't until she actually left American University, I think, and returned home that she came under the care of a neurologist who saw her.
Q. (By Mr. Murphy) Do you have any understanding as to why the plaintiff did not follow the recommendation to see a neurologist in October 2011?
MR. NACE: Objection.
THE WITNESS: I don't know the answer, but I think it's really pretty un-standard for a doctor to suggest to a student athlete that they see somebody but not set up an appointment for them. I don't know whether she knew where

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there was a neurologist locally.
But, no, I don't have the answer to that question.
Q. (By Mr. Murphy) When the plaintiff was seen at the emergency room and/or by the ENT, as you referenced it, was she ever diagnosed with a concussion by any of those healthcare providers?
A. She was not.
Q. Do you know if she gave any history to those healthcare providers that would have been consistent with a diagnosis of a concussion?
A. I don't know the precise history that they sought and in how much depth they sought that history. Certainly, an ENT specialist is not a concussion expert, and an emergency room doctor should have a little bit more experience with concussion.
But, I don't know, it wasn't -- the records I had didn't show the examination or the exact questions that were asked or not asked.
Q. Did you see records from Georgetown Emergency Room and the ENT?
A. I think I did.

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Q. From September 23, 2011, going forward, in the games and/or practices that the plaintiff did participate in, did she ever sustain any additional injury?
A. Not that's documented.
Q. When she went home over Thanksgiving break and was seen by her primary care provider, was she diagnosed with concussion at that time?
A. No. It was after the primary care provider referred her to the neurologist. The neurologist made the diagnosis of post-concussion syndrome.
Q. Did the neurologist make the diagnosis of a concussion or post-concussive syndrome on the first visit? Or did it take time?
A. I don't remember how many visits she had. I just know he made the diagnosis.
Q. Once the diagnosis was made of a concussion, did the plaintiff ever participate in any field hockey activities?
A. No, she did not participate in additional field hockey activities. She actually had to leave school.
Q. Do you know when she stopped academics?
A. I believe it was the spring semester that she

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stopped academics.
Q. Was that in response to a physician order? Or was that something she decided to do on her own?
A. I think it was some of both. She felt that she couldn't carry out her scholastic activities. She couldn't function. And ultimately, I think that she did get, not only from her own physicians but the school, support in pulling away that semester.
Q. Do you know when she returned to school?
A. It may have been -- I think it was the fall, but I'm not positive. I haven't reviewed that part of the record recently.
Q. How did she do in school once she returned?
A. She took longer to graduate than would have been expected, but she ultimately was able to graduate.
Q. Do you know if her grades were better or worse than they were before the fall 2011 semester?
MR. NACE: Objection.
THE WITNESS: I have not seen a listing of her grades. I am aware from the medical records -- or the records that she did not take a full complement of courses when she went

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back. She was taking, I think, three.
So she was on a reduced schedule and stayed on that. I never did see the actual grades for those courses.
Q. (By Mr. Murphy) What is -- and just sort of a brief summary.
What's your understanding of what the plaintiff has been doing professionally since she graduated from college.
A. My understanding is that she has been -- she is preparing to go to graduate school. But I don't have records that tell me, month by month, what she's been doing -- or I haven't seen records that tell me.
Q. Do you know if she's done any overseas traveling?
A. I do think there was a trip overseas, and it apparently did not exacerbate symptoms.
Q. What, if any, significance is that fact to you?
A. Not a lot. But if she had been extremely vigorous during that period of time and symptoms were not exacerbated, then that is something that you would have expected. Post-concussion syndrome might have been exacerbated if somebody was carrying out a

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great deal of additional physical exertion and/or cognitive exertion as compared with their baseline.
Q. Can changes in altitude exacerbate post-concussion symptoms?
A. I've not really found that to be the case in pressurized aircraft at 10,000 feet.
Q. And I'm not just talking about the fact of flying.
I mean, if you're just in, like, a high altitude area, up in the mountains or something like that for extended periods, does that have any impact on exacerbating PCS?
A. High altitudes can produce headaches and other symptoms, whether you have a post-concussion syndrome or not. In some cases, high altitudes have exacerbated post-concussion syndrome, and in others it hasn't.
Q. To your knowledge, has the plaintiff sustained any concussion since 2011?
A. Not that I've seen documented in records that I've seen.
Q. All right. Moving on to your opinions in this case, Doctor.
I'm assuming, based on your report, but

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correct me if I'm wrong, you have no opinions against any of the coaching staff at American University; is that correct?
A. That's correct.
Q. So, then, for purposes of my questioning, we will limit it to the athletic training staff -- Jen Earls and the head trainer, Sean Dash.
When I looked at your report, you had the statement there that as of the October 4 SCAT test, the standard of care required the healthcare providers to diagnose the concussion.
First question I have for you -- are you going to render the opinion that there were any breaches in standard of care prior to the October 4 SCAT test?
A. As I sit here today, I am not aware that I'm expected to be rendering opinions about standard of care for athletic trainers. But I certainly am very willing to render an opinion about what a person assessing a concussion should have done, or the diagnosis they should have made, and when it should have been made.
And, no, I'm not preparing right now. The information -- the first examination that I'm

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aware of is the date of the SCAT2 examination.
Q. Okay. So, then, this may shorten up my questions considerably. Let me ask you broadly.
As you sit here today, are you of the opinion that any athletic trainer at American University breached any applicable standards of care?
MR. NACE: Objection.
THE WITNESS: I believe that the athletic training staff at American University evaluated Jennifer and put her through a reasonable assessment for an athletic trainer, meaning the SCAT2 as of 2011. And abnormalities were found on that test, and it was reasonable that they did refer Jennifer on to Dr. Williams.
And at that point up through right where we are now, on the 4th and the 5th, I don't have a problem with the care that the athletic trainers provided for Jennifer.
Q. (By Mr. Murphy) Okay. And, like I said, that's going to help shorten at least my part of this deposition up considerably. Let me ask sort of a follow-up question to that.
I believe, if I have my information

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correct, that it was October 5th when Dr. Williams saw the plaintiff. And I'll let his counsel ask questions about Dr. Williams.
Specific to the athletic trainers, do you have any standard of care opinions against the athletic trainers once the plaintiff was seen by Dr. Williams -- from that point going forward?
A. Yeah, I'm not an athletic trainer, and we don't render standard of care opinions about athletic trainers across the field. I render standard of care opinions about assessments for a concussion, though, when that might involve an athletic trainer, and when that might involve a physician.
The person that I have the most criticism for in this case is Dr. Williams. And we'll get to that, obviously.
But when Dr. Williams used, "I can't identify a mechanism," as an excuse to limit concussion as a diagnosis, when all the symptoms were consistent with concussion, when it came after the night of a game in which she sustained head trauma, when that head trauma is on the SCAT2 form, documented by the athletic

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trainer, I think the trainer should have pushed harder to get further assessment. Because that wasn't a reasonable decision on Dr. Williams' part, and the athletic trainer should have understood that it's not reasonable.
But the athletic trainer does work under Dr. Williams, so I'm not holding that to be a standard of care.
Q. I think you said this in your report, but I want to make sure.
You don't have any problems or objections to the actual concussion management plan in place at American University, do you?
MR. NACE: Objection.
THE WITNESS: I think I do remember reading it. I don't sit here today and remember it word for word. I'm not sitting here criticizing that.
I do remember from the depositions of multiple people that that plan said if a concussion is diagnosed, the individual should be removed until symptoms have cleared, or at least until they're back to baseline. And then an exertional protocol -- that is all reasonable and appropriate.

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Q. Have we now -- well, I guess, as I understand your testimony, Doctor, you're not going to render the opinion that anyone at American University athletic training staff violated, quote, unquote, "Standards of care."
Is that -- to be as broad as possible, is that fair?
MR. NACE: Objection.
THE WITNESS: No. No, it's not.
In my opinion, Dr. Williams violated standard of care. And in my opinion, Dr. Higgins, as a responsible individual for the medical care being provided and, therefore, that Dr. Williams was doing the right thing, is responsible as well.
Q. (By Mr. Murphy) Okay. And I'm sorry if I misphrased that. I was kind of limiting my question, again, to the athletic trainers at American University. Let me ask you this question.
Do you have any criticism of any of the subsequent treating healthcare providers? And I'll start with the folks at Georgetown and the ENT.
MR. NACE: Objection.

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THE WITNESS: No. I don't have enough information. I just don't really know how thorough they were with their assessments.
Q. (By Mr. Murphy) Are you going to be rendering causation opinions in this case, Doctor?
A. Yes.
MR. MURPHY: Let's go off the record for a second, if we could, Madame Court Reporter.
THE COURT REPORTER: You got it. Off the record.
(Discussion held off the record.)
Q. (By Mr. Murphy) From a terminology standpoint on my part, in your mind, is there any difference between a mild traumatic brain injury and post-concussive syndrome? Or are they interchangeable and synonymous to you?
A. They're not synonomous.
And I don't like the term, "Mild traumatic brain injury," because if you have symptoms that last for months and/or years and/or are permanent, to me, that's not a mild brain injury. And it can be a life changing effect, depending upon what you're doing with your life or trying to do with it.
So I call it, like most are shifting to --

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a concussion is a traumatic brain injury, period. And a post-concussion syndrome is an ICD-10 code for one of the traumatic brain injuries. It's a code. And it means a traumatic brain injury whose symptoms have persisted -- most of us use more than one month.
Q. So in your way of thinking, would all post-concussive syndromes be traumatic brain injuries?
A. Yes. There are some of them that have as part of the post-concussion symptomatology emotional components -- cognitive behavioral and mood -- and some of them that don't. But they're all an outcome after a traumatic brain injury.
Q. Would you agree that in almost all cases, post-concussive syndrome symptoms eventually resolve?
MR. NACE: Objection. This is Matt.
THE WITNESS: Yes. Generally speaking, concussion symptoms in general, for about 80 percent of adults, will resolve within ten to 14 days. And with kids, 14 to 21 days.
Of the 20 percent that don't resolve in that period of time and go on to a

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post-concussion syndrome, the overwhelming majority will resolve within the first year. And less than two to five percent will go on beyond the first year.
And of those that go beyond the first year, most of those will even clear up, eventually, over time. And a very small percentage, one or two percent, will go on to permanent symptoms.
Q. (By Mr. Murphy) Do you know -- is there any explanation for why that very small percentage goes on to a permanent condition?
A. I think there is more than one explanation. One explanation could be that those individuals have structural brain damage that precludes -- enough of it that precludes a complete recovery.
It's also true that some in that group will go on to have emotional factors which can complicate recovery.
Q. In your report you talk about having the opinion that the plaintiff's injury would have resolved naturally within ten to 14 days.
Is that based on the statistics that you were just telling me a moment ago?

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A. Yes. That's based on what's most probable when she had her injury that was incurred on September 23 -- that if it had been recognized and properly managed, that most likely she would have cleared up within ten to 14 days.
Q. How important is it to have cognitive and physical rest within the initial 24 to 48-hour period following a concussion?
A. Depends on the severity of the concussion, but certainly it's desirable to have it in all instances.
Q. And why is that first 24 to 48-hour window of time so important?
A. Well, it's not just the first 24 to 48 with a more severe concussion. But certainly with virtually all of them, the metabolic crisis is going on mostly within the first few days. It may last as long as a week.
And if you don't have cognitive and physical rest in the early time period, you have a greater chance to provoke symptoms to have a more prolonged recovery.
Q. And explain that from a medical standpoint. And if you want, we can broaden it to a week, since you said it's not just 48 hours, but that

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it can go through the first week.
From a medical standpoint, if you don't have cognitive and physical rest within the first one-week period, how can that prolong the symptoms?
A. Well, I think the best way to think about a concussion is it's two processes. One is a metabolic process, and the other is a structural process. Let's start with the metabolic.
The metabolic process involves, among other things, ions within nerve cells, and within their connections, the axons being chaotically released as a result of the stretching and straining of brain tissue, so that sodium/potassium that are inside the cell exit the cell membrane wall, go to the extracellular space. So the positive ions go out and -- to replace that positive charge calcium, which normally sits in the extracellular space. Now it rushes into the cell and into the axon. Unfortunately, that calcium shuts down the energy mechanism of cells, the ATP pump, and so there's a metabolic crisis.

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In addition, neurotransmitters are chaotically released from nerve endings. And so you have, essentially, nerve cells that are alive but not able to transmit nerve impulses from one cell to the other.
Gradually, over the course of hours, or days, or a week, in most instances that disruption is corrected. The calcium is pumped out of the cell, takes energy, takes time, and the sodium and potassium are pumped back in where they belong. Neurotransmitters are put back on the end of nerve endings. And then hours, days, or a week later, in most cases, the cells are able to transmit impulses again.
That process is challenged if you physically try to make those cells work during that time period that they're most metabolically challenged -- work by either doing physical things or work by doing cognitive things -- for those cells that are involved with cognitive activity.
Also during the same time period, there is a swelling of axons, and in some cases an actual disruption of axons. And the swelling usually peaks within three days or four days,

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and has largely gone within the week. So that particular structural injury will largely be gone within days or a week or so, in most cases.
And, therefore, it's important for those two reasons -- the swollen fibers as well as the metabolic challenges that we mentioned, that rest be -- physical and cognitive rest be occurring over the acute time frame in symptomatic concussive patients.
Q. Where does the decreased cerebral blood flow fall into line in that scenario?
A. Yeah, it's paradoxical, because at a time period during those first seven days when you would expect you needed more blood flow to correct the metabolic disruption, there's actually a decrease in blood flow, which slows that recovery. But that usually, on its own, normalizes out by the end of a week.
Q. Will it normalize on its own if there is no rest period for the patient?
A. In many instances it will, and in some instances it won't.
Q. What's going to happen to the disruption and the structural injury, and the metabolic

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process, during the first week if the patient does not rest at all?
A. If the patient exerts physically or cognitively and exacerbates symptoms, then you're going to expect those symptoms to be longer-lasting before they recover. You don't really expect to injure the brain in most instances, but you certainly do expect that you're going to stretch out the amount of time it takes to recover.
Q. You stated for me at the beginning of this topic some percentages for when you expected concussive symptoms to resolve.
Are you aware of any similar studies that would predict how long concussive symptoms would last if someone does not undertake cognitive or physical rest in the first one week following an injury?
MR. NACE: Objection.
THE WITNESS: The problem with the type of studies that you're talking about, which have been done in animals, is that when you're talking about concussion in humans you're talking about a spectrum of injury, and you're not talking about -- all concussions are not

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created equal.
So there really are no good studies that will tell us exactly, if you don't rest in the first 48 hours, what the recovery is. The recovery for a number of people in that first 48 hours is they're going to clear up from their concussion symptoms, whether they rested or not.
Q. (By Mr. Murphy) If you have a scenario where a person sustains a concussion and they participate in full activities for the first week after the injury, is there any way for you to predict how long their concussive symptoms will last in that scenario?
MR. NACE: Objection.
THE WITNESS: No. No, just that it's expected to last longer than it would have otherwise.
Q. (By Mr. Murphy) Does that increase the risk for a permanent injury? In other words, if a person doesn't rest in the first week following a concussion, does that increase the chances that their PCS will become permanent?
MR. NACE: Objection.
THE WITNESS: I don't think we know the

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answer to that.
Q. (By Mr. Murphy) Can biological factors influence the longterm prognosis for a concussion patient?
A. Absolutely.
Q. And give me some examples of biological factors which would increase the chances of longterm PCS following a concussion, even if they rest on day one.
A. I already gave them to you, but they include ADD, ADHD, panic attacks, anxiety disorder, depression, migraine headaches, seizure disorder, any learning disability.
Q. How about gender -- female versus male?
A. Females recover as a group more slowly than males, and tend to have more symptoms than males, and have a higher incidence of concussion in the same sports that males and females play, like ice hockey, soccer, basketball.
Q. I've seen references in the literature to physiological factors.
How does that differ from biological factors?
A. Well, the biologic factors that we were listing

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were conditions that are present in some people prior to a concussion. And if you have those biologic conditions, then you are predisposed to a slower recovery from a concussion.
In the case of females having more concussions and slower recovery than males, there are probably two million theories with regard to why that is, although nobody can say those are the only two reasons.
One is a psychological reason, in that women as a group -- not individual woman, but as a group -- are more honest than guys in reporting their symptoms, including at baseline.
And, also, women have much weaker necks. So it's felt there are mechanical reasons why women may have more concussions than guys as well.
Q. Can social factors influence duration of concussion symptoms?
A. I guess psychological factors/social can play a role in some cases.
Q. Doctor, I'm going to ask you what's going to sound like a really bizarre question now, if all of mine haven't already.

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MR. NACE: Objection.
Q. (By Mr. Murphy) But I have to ask this for a certain legal reason.
I want you to assume, hypothetically, that between October 1 and October 5, the plaintiff was continuing to play in full field hockey activities.
Did her participation in field hockey activities during that four-day window have any longterm effect on her concussion, as opposed to what she has done in the days prior and the days after October 5?
MR. NACE: Objection.
THE WITNESS: I guess my answer would be that I believe that she was concussed on September 23, 2011, and, it is true, did not report those symptoms immediately to the training staff. And I believe that all of her subsequent practices and games that she played after that date probably contributed to the very prolonged post-concussion syndrome that she ultimately sustained.
Q. (By Mr. Murphy) And I understand that. My question's a little bit different.
The fact that she played on four days --

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or may have participated in field hockey activities on four specific days between October 1 and October 5, does that in and of itself impact her injuries at all in this case? Just the cumulative effect after 09/23.

MR. NACE: Objection.

THE WITNESS: Well, I'm sorry if my answer wasn't clear.

What I was trying to say was that it all contributed, so that is a part of the contribution.

So, yes, I would say those four days were part of the contribution. I can't tell you a percentage, but definitely I would not say that those four days were immune from contributing.

Q. (By Mr. Murphy) Let me ask you the converse question, and this is obviously a hypothetical.

But if, hypothetically, for whatever reason she rested on October 1 through October 5, and everything else was the same in this case, would you be able to say there would be any difference in her outcome today?

MR. NACE: Objection.

THE WITNESS: I wouldn't be, because on October 4 as well as on October the 5th, she

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had a pretty high number of post-concussion symptoms and severity score. And then she went on from that point to continue to play while symptomatic. And it's that continuing to play and continuing to play while symptomatic that I believe is responsible for her prolonged post-concussion syndrome.

So if she had stayed away just those four days but still had the same symptom scores and severity scores on the 4th and the 5th on her SCAT testing, then I would not have expected that the staying away would have made much difference.

Unfortunately, we're never going to know, because to answer the question you'd really have to have had SCAT scores, I guess, on the 1st, and then compare them to what they were on the 4th in -- a resting four days, versus what happened here.

Q. (By Mr. Murphy) Earlier on, you told me that it did not appear that she sustained any additional injuries after September 23.

You're familiar with the second hit syndrome; correct?

A. Very well aware of it, yes.

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Q. So explain to me, in your opinion, how the continued play without a, quote, unquote, "Second hit," or another injury made her concussive symptoms prolonged or worse -- however you want to describe it?

A. Well, first of all, the second-impact syndrome is a dysautoregulation, with rapid inflow of blood flow to the brain that usually leads to brain herniation and coma within a matter of minutes. She did not have that.

But just from the exertion of driving up your heart rate and your blood pressure, you can aggravate concussion symptoms. And you can aggravate the symptoms just by being jostled about in the way that you'd play a sport -- not necessarily having taken any blow to the head, itself, but just by being pushed, or shoved, or hit in the back, or hit in the chest, the head can be accelerated.

Now, the question that was asked of me -- did she have any additional head trauma?

And my answer, I believe -- what I tried to say was none that I saw documented.

Did she have additional head trauma from the additional practices and games that she

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played? Unquestionably.

Q. And why do you say that, Doctor?

A. You can't be playing those sports without taking some head trauma, if you're already in a susceptible state such as having post-concussion syndrome.

Q. Would that be in any way something that could be detected or diagnosed?

A. It could be detected by the symptoms getting worse. And she did say on some occasions that after the exertion of a game, her symptoms were worse. That's what you would expect.

Q. When do you believe her PCS became permanent?

A. Well, I believe that her PCS is most probably permanent, as I said, because it's now been there years and it's not cleared.

I don't know that I can give you a date when it became permanent, but it most probably became permanent when it was there for four or five years and hadn't gone away.

Q. So if, hypothetically, a neurologist who comes along in the spring of 2012 prescribed complete cognitive and physical rest for her, would that have altered the outcome, and had time for the PCS to no longer become permanent, in your

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opinion?
MR. NACE: Objection.
THE WITNESS: No. I think by the spring, the damage had been done.
Q. (By Mr. Murphy) So that's what I'm trying to understand.
So you told me a minute ago you couldn't put a time period on when her PCS became permanent. But you said by the spring, the damage had been done. So I'm trying to get those two to make sense to me.
A. All right. I think the damage was done while she was allowed to continue to exert in practices and game play in the fall of 2011.
The question was, when did it become permanent? Well, I could only say that I think most probably it became permanent when she still had symptoms three or four years later, because the likelihood, statistically, of it now clearing up is now very low.
But it did become permanent from -- at some point in the fall of 2011. I couldn't have known that was going to happen at that time, though.
I hope I'm being clear. I'm willing to

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take another whack at it if I need to.
Q. No. I'm trying to follow you, Doctor, and I'm sure other counsel will follow up as well for the question. But let me ask you a -- sort of a different question.
If, hypothetically, the emergency room personnel at Georgetown Hospital had diagnosed her with a concussion whenever they saw her in October of 2011, and from that day forward she stopped all field hockey activity, do you think there would have been a different outcome in this case?
MR. NACE: Objection.
THE WITNESS: It's possible. It's possible. I don't know.
Q. (By Mr. Murphy) Same question, I assume same answer, with the ENT -- if the ENT had diagnosed.
It's possible; correct?
MR. NACE: Objection.
THE WITNESS: Yes. The answer would be exactly the same. It's certainly possible there could have been a different outcome. I don't know.
Q. (By Mr. Murphy) How about if the plaintiff had

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followed through with the recommendation and seen a neurologist in October 2011? Do you think, under the care of a neurologist at that time, we could have had a different outcome in this case?
MR. NACE: Objection.
THE WITNESS: The answer would be exactly the same. It's possible. I don't know.
Q. (By Mr. Murphy) I guess with the neurologist question -- if she's under the care of a neurologist, would it become more probable, because of the care and treatment provided once the diagnosis of a concussion was made?
MR. NACE: Objection.
THE WITNESS: The really underlying question is, when did her post-concussion syndrome become permanent from the trauma that I believe she received in the fall?
And I believe it became permanent because of the repetitive trauma that she got from practice and game play. And I don't know whether it had already become permanent at the time she might have seen a neurologist.
I think the sooner she would have been shut down, the greater the chance that the

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outcome would have been different. But because I don't know precisely when it did become permanent, I can't tell you, exactly, that date.
Q. (By Mr. Murphy) And you can't even narrow it down, you know -- October 1, versus November 1, versus December 1; is that fair, Doctor?
MR. NACE: Objection.
THE WITNESS: I think it's fair to say the longer she was taking head trauma, the greater chance it contributed to her post-concussion syndrome being permanent.
Q. (By Mr. Murphy) What impact do you claim that academics have on her PCS?
A. Not favorable.
Q. What do you mean by that?
A. Ideally -- if she was having the difficulties that she was having cognitively with her studies, it would have been ideal if she could have had some accommodations made so that she was not asked to be taking exams or necessarily keeping up with the same cognitive load that she had prior to her concussion.
Q. If, hypothetically, she had stopped playing field hockey on September 23 but continued with

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all of her academic studies, would there have been any difference in her outcome?
MR. NACE: Objection.
THE WITNESS: Most probably, there would have been a difference in the outcome. Yes.
Q. (By Mr. Murphy) Did you review the care and treatment --
MR. NACE: Hold -- hold on. You cut out. If you can repeat from where you started from, that would be great.
MR. MURPHY: It was a brilliant question, Matt. All right. I'll restart.
Q. (By Mr. Murphy) So, Doctor, have you reviewed the care and treatment that was provided to the plaintiff after she was diagnosed with the concussion?
A. I have not. I've seen some of it. I've certainly not seen all of it.
Q. Are you going to render any opinions as to whether or not it was fair, reasonable, that type of thing?
MR. NACE: Objection.
THE WITNESS: That that I'm aware of I believe is reasonable. I'm not sure that I've seen all the treatment she may or may not have

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received.
Q. (By Mr. Murphy) When you are treating a patient with a diagnosis of a concussion that is not responding to physical and cognitive rest alone, what do you introduce into the treatment plan in the general sense?
A. Well, it's a two-tiered approach.
The first approach is to identify what silo or what grouping of symptoms the individual has problems with, and then detect therapy toward those symptoms.
Secondly, if that therapy is not completely able to allow the individual to recover, then there is pharmacology that can be used as well. For instance, the grouping of symptoms that we normally identify after concussion are cognitive symptoms such as those that she has: her computer's working slower, her processing speed is down, complex processing is not where it once was. Simple things, she does quite well on.
If one is having cognitive problems, then cognitive therapy is the first treatment for the individual. And that involves not just memory programs but, most importantly, a whole

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list of things that you can do to help you remember and retain information. You can think of them as tricks, if you want.
On the other hand, another domain is the domain of balance and vestibular problems. And here what the patient normally has is trouble with her balance, trouble with dizziness. They may have blurred vision, they may have trouble with eye tracking.
If that's the problem, you refer them to a vestibular therapist and/or a vestibular and an ocular therapist, and you direct eye therapies -- eye tracking therapies. You just give balance exercises to the patient.
On the other hand, if the patient has primarily somatic symptoms such as headache, neck pain, pain from the top of the neck radiating up to the top of the head so it sounds cervicogenic in nature, then it's a specific cervicogenic kind of PT that you're recommending for the patient.
If the patient goes through treatments in those areas -- say cognitive areas, and they improve a bit but they're still having troubles, then there's a whole wide range of

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pharmacology that can be considered if the recovery's not felt to be adequate.
And the same kind of thing -- different types of medication can be used for pharmacology for people that have trouble with behavior and mood issues, with impulsivity, with depression, with anxiety. There's medication that can be used there if the therapy alone doesn't work.
So it's really a two-tiered approach. One are therapies directed toward the symptoms. And secondly, if the therapy alone isn't adequate, then there are medications that can be tried if you want to do that.
Q. Do you have any idea if that two-tier approach was ever implemented with this plaintiff?
A. I never had the opportunity to sit down and examine this patient and go through, in any detailed way, exactly the therapies that were given. I'm not aware that she necessarily has gone through all of that.
Q. Say, hypothetically, that she has not gone through that two-tier approach that you just outlined for me.
Is it possible that with that approach,

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her symptoms would improve with time?
MR. NACE: Objection.
THE WITNESS: Now that she is seven years out from her injury without resolution of symptoms, it would be unlikely. You could never say it couldn't happen. You could never say you wouldn't try it. But it would be unlikely that suddenly, seven years out, she would clear up from all of her symptoms.
Q. (By Mr. Murphy) For the tier one therapy that you were just talking about, over what period of time should that be attempted?
In other words, is this something you try for a couple of weeks, and if it doesn't work you move on? Or what's the time frame?
A. Yeah. It's normally more than a few weeks. It's normally not more than a few months. And it's normally something that's done within the first year of the individual -- if an individual is seen within a month or two of their concussion -- even if you're out three or four or five months. You'd institute it sooner rather than later, if you're going to do it.
Q. Can a patient's subjective belief regarding outcome impact her recovery?

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A. Somewhat, yes.
Q. In what way?
A. Well, if somebody has it in their head that they're not going to get better, that can be a negative -- it can increase one's chances of having a negative outcome.
Q. Can a litigation increase one's chances of having a negative outcome?
MR. NACE: Objection.
THE WITNESS: I think that's been well documented.
Q. (By Mr. Murphy) That it can; correct?
MR. NACE: Objection.
THE WITNESS: Yes, it can. In certain cases, probably does.
Q. (By Mr. Murphy) Have you reviewed any of the plaintiff's cognitive test results in this case?
A. I've reviewed the two neuropsychological tests. I think one was done in 2011, one in 2012.
Q. Would you agree with me that the cognitive testing was all within normal limits?
MR. NACE: Objection.
THE WITNESS: No.
Q. (By Mr. Murphy) In what way do you disagree?

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A. I realize you have an expert that's given the opinion that it's all normal, but I think the opinion of the people that did the testing is that in each of those assessments, there were several subtests that showed that she was having some problems that -- you would not be expecting a person at the college level to be testing that low. Overall, her cognitive tests, though, it's true that they were primarily in the average range.
MR. MURPHY: You still there, Doctor?
THE WITNESS: We've got the audio, but not the video.
MR. MURPHY: As long as you can hear us, Doctor, and we can hear you, we'll just keep going on.
THE WITNESS: Very good, sir.
MR. MURPHY: If you stop answering my questions, I'll assume you've dropped off.
THE WITNESS: You would be right.
MR. NACE: I want to take a break when you're done.
Q. (By Mr. Murphy) Have you ever had an athlete with PCS go on to get better grades after the injury than before the injury, to your

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knowledge, Doctor?
MR. NACE: Objection.
THE WITNESS: Yes, I've had that happen. And I've had many people with PCS go on to equal the grades that they had before. Usually, not at the time they're having the greatest amount of problem with PCS, though.
Q. (By Mr. Murphy) Have you ever had people still suffering from PCS who go on and get advanced degrees?
A. Yes.
Q. Have you ever had people with PCS go on to learn new languages?
A. I don't recall, to tell you the truth, that I honestly remember whether anyone has tried learning a new language. I just don't know. I don't see any reason why they couldn't, but I honestly don't know.
Q. That was going to be my next question. Would there be any reason why they couldn't because of the PCS symptomology?
A. No. If someone is still having processing speed issues, it's not an on-off switch. It's not a black or white. It's just that it takes you longer to do what you could in a much

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shorter period of time before, in instances when it's not extremely severe. And that's kind of where her testing was.
Q. Let me try and ask it this way.
Is it your belief that the plaintiff can do everything today that she would have been able to do had there been no concussion, it just may take her a little bit longer to accomplish it?
A. I wouldn't know the answer to that without seeing her or examining her. I wouldn't want to make that comment based on just neuropsychological testing.
Q. Doctor, have we now gone over in broad strokes all the opinions that you are prepared to render in this case?
MR. NACE: Objection.
Q. (By Mr. Murphy) And, actually, you know what? Let me amend that, because we really haven't talked about -- I know you have some opinions as to Dr. Williams and Dr. Higgins, and his counsel's going to get into that in a moment.
Insofar as American University is concerned, the athletic training staff there and your causation opinions, have we now

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covered the outline of your opinions?
MR. NACE: Objection.
THE WITNESS: I think you've very nicely covered causation, and I think you've quite comprehensively covered, generally, opinions about American University and opinions about the athletic training staff.
I don't know what other questions might be asked of me on the stand. And if they are asked, I'm going to answer them to the best of my ability. But short of that kind of situation, I think you've covered it all.
MR. MURPHY: Well, I'll tell you what. Let me -- I'm going to pass the mic, so to speak. I want to review my notes, because I want to make sure I didn't miss anything in your expert designation that we haven't talked about, Doctor.
And Matt, Barry, if you think I'm missing something in broad strokes, let me know. We will speed this along.
Otherwise, I'll pass the questioning to Rob.
MR. NACE: Mind taking a brief break so we can see if we can get the doctor back on video,

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and I can run to the restroom?
MR. MURPHY: Sure. Absolutely. I don't want to hold you without a restroom break. But if we mess around with the video, it'll only get worse.
(Recess taken from 2:55 p.m. to 3:04 p.m.)
EXAMINATION
BY MR. MAYNARD:
Q. Dr. Cantu, can you see and/or hear me?
A. I can hear you. I can't see you.
Q. Okay. Again, if you don't hear me given the video hookup, by all means let us know so we make sure we are communicating; okay?
A. Yes, sir.
Q. Did you say that for adults, in about 80 percent who have a concussion, the symptoms will resolve in ten to 14 days?
A. Yes. Generally speaking, that's true.
Q. And, then, when is it you could say that a person with whom the symptoms do not resolve has post-concussion syndrome?
A. There are two different definitions. One starts at three months, and the other starts at one month. Most of us use one month.
Q. And do I understand that there's not a

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particular date you can point to to say, had for whatever reason plaintiff sat out, rested both physically and cognitively -- where you could say if that had been down, she would not have developed likely post-concussion syndrome?
A. Well, I think that it was not the fact that she didn't sit out physically and mentally acutely that's the big issue.
The bigger issue, in my mind, is that she exerted at a high level as she continued to practice and then play games with field hockey for many weeks after she first had her concussion and was still symptomatic from her first concussion.
And I believe that it's that physical activity primarily, and the jostling that would occur with practice and play in field hockey, that is responsible for this very protracted post-concussion syndrome.
Q. So with that modification -- that's a good point about the type of physical activity.
But am I right that you're not able to pinpoint a date by which you say if she had stopped that type of activity, she would not likely have developed PCS?

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A. No, I can't state a specific date. I'd simply say the sooner that she would have followed good concussion protocol, the greater the likelihood that she would have recovered. But I can't give you a specific date, no.
Q. What's the incidence of PCS in -- okay.
Are we counting, by the way -- we consider her, the plaintiff, for our discussion as adult?
A. Essentially, yes.
Q. What is the incidence of PCS for an adult?
A. Roughly 20 percent.
Q. And then you gave us the numbers of those -- where the symptoms resolved within a year -- two to five percent.
And then one to two percent have permanent PCS or permanent symptoms?
A. Yes. There's not perfect science to give you those percentages, but generally speaking, that's what's quoted in most of the publications.
Q. And, again, you didn't, I assume, calculate exactly between -- as you said, between September 23 and October 1, and October 1 to October 5 or thereafter, exactly how many games

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and practices Jennifer Bradley participated in.
A. That's correct.
Q. And I think you just said you knew it was multiple.
A. Well, I was being asked for a much shorter period of time when I said it was multiple. But I don't have an exact tabulation of how many games she played, and I have even less of an exact tabulation of how many practices she participated in during the month of September after the 23rd and during the months of October.
Q. And when you were answering questions before, when Mr. Murphy -- he had used the word, "Outcome."
What were you meaning by outcomes? Just PCS, or symptoms of PCS?
MR. NACE: Objection. This is Matt.
THE WITNESS: I'm not able to remember the exact question that you're referring to. If we could restate a question in which I used, "Outcome," I'd be happy to give you the answer. I don't remember the exact question you're referring to.
Q. (By Mr. Maynard) Do you have any opinion in

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this case if, let's just say hypothetically, from the 23rd she had not participated in field hockey or practices, and rested cognitively for, you know, three days to seven days? Do you have an opinion -- would she have passed her Return to Play protocol?
A. Well, by the very statistics I gave you, she'd have an 80 percent chance to be asymptomatic in two weeks, and she'd have a 98 percent chance to be asymptomatic within a year.
So, obviously, if she had stopped and received proper protocol on the 23rd, overwhelmingly the likelihood would be that she would be asymptomatic at this point.
Q. And did you say there are some patients who do recover who don't follow -- who don't rest? So athletes who keep playing, for whatever reason.
A. Well, there are athletes who suffer a concussion and don't rest and do recover from their concussion. That's correct.
Q. Why does that happen for some and not others?
A. Presumably, the concussion was of a minor enough severity that they were capable of recovering, even though they didn't go through the extra physical and cognitive rest that

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would be recommended acutely.
Q. Did you put any adjective on the type or the severity of concussion you think the plaintiff sustained on September 23?
A. Yes. Based on the duration of symptoms, I would say it was a severe concussion. But that's complicated by the fact that it wasn't treated correctly. So I don't know how much of the severity is related to the blow sustained on the 23rd that didn't seem to be very much, versus the fact that she continued to physically and cognitively -- but especially physically exert on an almost daily basis thereafter.
Q. You had cited some, I don't know -- do you consider being female -- is that a risk factor for developing PCS?
A. Not PCS, but to have a higher number of concussions and recover more slowly. But not necessarily up to the PCS level.
Q. Did the plaintiff have any risk factors to develop PCS?
A. Well, once again, I didn't examine her, and I didn't get a chance, therefore, to go through whether there was anxiety, depression, panic

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attacks, migraine, and so on -- ADD, ADHD, learning disability, dyslexia, in -- prior to her concussion.

I didn't see it documented in the medical record, so I don't know the answer. Presumably, not there, but don't know.

Q. Are you going to offer any opinions that with any -- again, for whatever reason she had rested at certain times or had different treatment, in terms of outcome, she would have gotten different grades -- better grades, graduated sooner?

Anything like that?

A. She was concussed on September the 23rd, and she continued to practice and play field hockey games through November the 4th. The longer that went on, the greater the chance that her post-concussion syndrome was going to become permanent and last, therefore, a very long period of time.

I can't tell you when that happened. I can just simply say, generally speaking, the sooner the correct protocol had been instituted, the better the outcome most probably would have been.

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Q. And you just used the term, "Outcome," there.

Are you using that to describe PCS symptoms she may have, or more? Like, she would have graduated? That type of thing?

A. Yes, I'm using it to refer to PCS and her problems that are the result of it, which included slowed processing time, not being able to take a full course load, taking a longer period of time to graduate, and possibly even taking more time to not only graduate, but figure out whether she was going to go on and what she was going to go on to after graduation.

Q. Let me ask you about Dr. Higgins.

Tell me what your opinions or criticisms are of Dr. Higgins.

A. Well, generally speaking, from his deposition it became pretty clear that he didn't understand post-concussion syndrome. He didn't understand what it meant, and didn't understand the role of persistent physical activities in greatly aggravating a concussion.

He held himself out to be, and I'm sure he is, a very fine orthopedic surgeon, but did not indicate that he had special knowledge, or

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awareness, or training in concussion.

In fact, he went on in his deposition to say he didn't recall a single concussion case at American University. And if he did have a concussion, he would refer it. He wouldn't try to treat it himself.

If he's where the buck stops for these athletes, as he's the team physician for the entire university, you would have thought that he would have had some concussion cases, whether he treated them or not. So I guess those cases either were unrecognized or went elsewhere.

He, because he is responsible for the care of athletes, is responsible for the care of people under him. And that's where I feel that he does bear a responsibility for the inappropriate care that Dr. Williams delivered.

I realize completely that Dr. Higgins did not see this patient and was not aware of this patient's condition, but this happened all on his watch. And if he was going to have somebody be responsible for this athlete's care, then he had a responsibility to know that this person had the knowledge to deliver

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correct care. And, obviously, that wasn't demonstrated in this case, at least in my opinion.

Q. And in your notes -- do you have them in front of you?

A. I do.

Q. The last note with a star, you wrote, "Dr. Higgins doesn't understand PCS -- persistent concussion SYM" -- meaning symptoms. "Have to first have concussion to have PCS."

Do you see that?

A. Yes.

Q. Tell me what you meant by that.

A. On pages 88 and 89 of his deposition -- and if you want me to go to those pages, I'm happy to do it to be more specific.

But generally speaking and on those pages, he made it clear, at least to me, that he did not understand the issues of post-concussion syndrome. He did not understand that concussion symptoms can be delayed, and he did not understand that an athlete may even not be able to remember the concussion because of amnesia from the hit to the head in the first place. So, clearly, he doesn't understand the

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issues with regard to concussion.
I realize the defense of Dr. Williams is that no mechanism was found. But that's not a defense, because in a very significant number of concussions, you never do find the particular hit that caused the symptoms.
The symptoms may be delayed. The patient may come in even the next day or a day or two later complaining of concussion symptoms. And even when you go through the videotape of a game, you may not see one hit that seemed more egregious than another.
So this concept that you have to find the hit that caused the concussion or else a concussion didn't happen is just rubbish.
Q. Well, in your note where you say, "Have to first have concussion to have PCS" --
A. Yes.
Q. Is that what you're noting that you believe he said?
A. Yes. He did not seem to understand that you had to have a concussion to have post-concussion syndrome.
Q. All right. So that's what I want to make sure of.

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You're saying you need to have a concussion to have post-concussion syndrome?
A. That's correct.
Q. And you said in -- I don't know what word you just used. In some number of cases, a mechanism isn't described by the historian.
How frequently does that happen, in your experience?
A. Well, it depends. In my experience, we've certainly had it in a significant number of cases -- maybe ten, or 15, or 20.
But there have been publications in the literature where they have had nearly 30, 40 percent of football players not describe concussion until the day after or two days after the game, when they came into the training room on a Monday after a Saturday game and complained of concussion symptoms.
And it's also true in the National Football League. This last year, there have been a number of players who are not diagnosed with concussion on the day of the game, but were diagnosed with concussion when they came into the training room on a Monday after a Sunday game and complained of symptoms that

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they were either not aware of or were not complaining of on the day of the game.
Q. This case is not a delayed symptom issue, is it? Didn't you say the plaintiff described from the get-go on the 23rd that she had certain symptoms that day?
MR. NACE: Objection.
It's not on the record.
THE WITNESS: I think that she didn't have the symptoms or wasn't aware of them during the game. And when she did have them later, I'm not sure that she connected the dots that this could be a concussion.
And I think that -- I'm not faulting, as I've indicated previously, the athletic trainer who was not made aware of these symptoms until early October with not having picked them up sooner.
Because if the patient doesn't come to you and explain the symptoms, and doesn't take an outrageously egregious hit where you obviously see somebody who looks like they're in trouble because they're getting up very slowly or staggering about on the field, et cetera, you have no way of knowing whether they've suffered

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concussion symptoms, unless they say they've got them and you examine them and find that they do, indeed, have symptoms on a checklist, and do indeed have deficits on neurologic testing.
Q. (By Mr. Maynard) In this case, do you have an opinion on what the mechanism of the concussion was?
A. I assume the concussion was the shoulder that hit her head on the 23rd.
Q. Which the plaintiff described even six months later to the neurologist -- that actual hit and that relationship; right?
A. No. That relationship is on a SCAT scan that -- it's handwritten by the athletic trainer on October the 4th.
Q. Didn't this issue about not knowing the mechanism -- doesn't it seem like in the records the plaintiff described what you're saying is the mechanism?
She's the one that says, even months later, "Oh, I got hit in the head on September 23."
A. No. That's not the way I understood the records. When I looked at the SCAT that was

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done by the athletic trainer, and there were three of them that were done -- one of them on the 4th and one of them on the 5th.

And there's handwriting on the SCAT scan that was done 10/04/2011 that says, "Richmond: dizziness after getting shoulder to head. Afterwards felt fine. Game went on. Then symptoms began" -- it seems like she said, "Cognition."

And that SCAT scan is highly abnormal. It had 17 concussion symptoms and a symptom score of 45, as compared with her baseline SCAT2 test that had eight symptoms and a symptom score of 21.

So the mechanism is handwritten on that scan -- on that SCAT study by the athletic trainer. Dr. Williams never looked at that SCAT scan, according to his deposition. And that's why -- and one reason that he didn't understand the mechanism of the injury.

But even if he hadn't gotten a mechanism of the injury, this was a concussion until otherwise ruled out, and it should have been managed as a concussion. But the mechanism of the injury is right there, handwritten by --

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I'm told from the depo that that's the handwriting of the athletic trainer on 10/04/2011.

Q. And that was obtained historically from the plaintiff?

A. Well, I don't know where else it would have come from.

Q. So that's why I had asked you.

The plaintiff -- this issue of you've seen patients, or athletes, or what have you come in and don't know the mechanism themselves, or can't give a history because they simply don't remember it -- that's not this case, is it? According to you, she knew when she took the hit.

A. Well, in this particular case, she seemed to remember that hit, at least on 10/04/2011.

Q. Tell me, is it your opinion that in terms of Dr. Higgins, that from what he knew of Dr. Williams' background, that was not a sufficient clinical background that Dr. Williams had to be left in the position he was?

A. Well, according to the deposition, Dr. Williams said he had a whole one month of neurology as

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part of his primary care training, and we don't know whether any of that was managing athletic head injuries. I wouldn't say that's a robust treatment -- I mean, a robust amount of experience.

I think it was incumbent upon Dr. Higgins to understand what Dr. Williams knew about concussions. And, obviously, he didn't know very much, and he certainly didn't know a very basic thing, and that is that you don't have to find the mechanism to diagnose concussion. Because the athlete, not infrequently, will not be able to give you the mechanism.

Q. Do you have any explanation as to why the plaintiff wouldn't have said to Dr. Williams, "I took a hit to the head on September 23"?

MR. NACE: Objection.

THE WITNESS: I don't know the line of questioning that Dr. Williams used or didn't use. And so, no, I can't give you for sure the answer.

Generally speaking, the patient is going to give you direct answers to the questions you've posed to them. They're not going to come and give you the diagnosis and the

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mechanism off the tip of their tongue.

Q. (By Mr. Maynard) To what degree of clinical background would Dr. Williams have needed, in your opinion, such that Dr. Higgins could then have felt comfortable leaving him in that role?

A. Well, Dr. Williams -- in all fairness to him, he's a fellow. He's in training. He's learning. He's not somebody who's already fellowship-trained and ready to necessarily assess concussions on his own. And, yet, that was the role that he was thrust into.

And by his own deposition, it's clear that he's had very little training in neurology. He didn't know whether there was, under -- again, his deposition -- he didn't know whether there was a NCAA concussion handbook on file at American University. There was. That's a credit to American University. It's not a credit to him that he didn't know it was there and didn't know what was in it.

But he did know that if somebody were diagnosed with a concussion, they should be pulled out. And that's correct and that's good.

The assessment that was being used for

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concussion was a SCAT2 study, which is somewhat superficial as standalone. But going back to 2011, I don't have a great problem with that.

But, clearly, his understanding of how you diagnose concussion was very highly flawed. This concept that you have to come up with a mechanism or you can't diagnose a concussion -- that's just very, very flawed, and is I'm sure because of his inexperience and his lack of training.

Q. Is your understanding that Dr. Williams had -- was he a Board-certified family practicioner at the time he was seeing the plaintiff in October 2011?

A. I think he was. I believe he was.

Q. All right. Is it your understanding that he had military experience, including with concussions?

A. I don't know how much with concussion, but I know that he had had military experience. Some of the records indicate that.

Q. Did you say -- I'm going to move back. Did you read his deposition?

A. I read his deposition.

Q. All right. Well, let's assume he said in there

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he also had diagnosed and seen concussions -- diagnosed concussions in the military.

Why is, from Dr. Higgins' perspective, having a Board-certified family practitioner, who in addition has been in the military -- why is that not sufficient training or clinical background for Dr. Higgins to say, "Okay. You can be the team physician," in this kind of case?

A. What I'm trying to say is that Dr. Higgins, in my opinion, was at the head of the command chain. He was the person responsible for the medical care these athletes were getting. He can delegate that care to other people, and it's a good idea that he does because he's saying that he doesn't manage concussions himself.

But what I'm saying is if he's going to delegate that care, he has an obligation to be certain that that person can carry out that care correctly, or else he is partially responsible for problems. And he didn't do that. You can't rely on just the fact that somebody has been Boarded in a given field. You need to know whether they've had concussion

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training, whether they understand concussions. And, obviously, this whole idea about mechanism is what derailed the correct management here.

I don't really have a high problem with what happened before Dr. Williams saw this patient, because the patient wasn't complaining of symptoms to the athletic trainer and bringing it to the athletic trainer's attention.

But once that did happen, the failure to correctly manage the case all hinges on this hypothetical, "Can't determine a mechanism, so it can't be a concussion," which is basically flawed -- totally wrong.

Q. I understand that. And I may ask you, too, and other counsel ask you about Dr. Williams.

But how is Dr. Higgins supposed to determine, when he has a Fellow coming through this military program -- what is he supposed to do, in your opinion, to assure him that Dr. Williams, a Board-certified family doctor, can manage concussions or anything else he's going to see as a team physician?

A. Well, he's -- in my opinion, he's going to have to either, himself, or delegate it to a

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neurologist or somebody he has confidence in -- to sit down with this doctor and have this doctor explain his knowledge about concussion and how he would handle concussion patients, et cetera.

And if this doctor were to tell him as part of his management of concussion that he had to determine the mechanism, and if he didn't determine it the patient wouldn't have a concussion and would not be treated as a concussion, then that's an immediate situation where the person would need further education that that's not correct.

This doctor is in training. He's learning. That's why he's doing what he's doing. But you learn not just in the dark, in the absence.

As I indicated, I'm not holding it to a standard of care, but I do find that this athletic trainer could have pushed harder on this doctor when that mechanism was what was preventing concussion management to occur. The athletic trainer should have known that's not right.

But as I said, the management of these

conditions is the responsibility of Higgins. If somebody is egregious in their lack of knowledge, that should have been noted prior to them starting.

Q. In your opinion, did Dr. Higgins have to have other specialists sit down with Dr. Williams to test Dr. Williams' knowledge of treatment of other things -- pains, bruises, anything else?

MR. NACE: Objection.

THE WITNESS: No. Probably, those other things don't rise to the significance of a brain injury. So I wouldn't be concerned that as a family practitioner he wouldn't be able to handle routine orthopedic or routine musculoskeletal issues.

But when you're dealing with brain issues, yes. If no one else is going to be checking on him, then -- and Dr. Higgins is not going to check on him, then Dr. Higgins better be sure that he knows what he's doing, or else --

Q. (By Mr. Maynard) Go ahead.

A. Or else he, in my opinion, is not fulfilling his obligation to American University.

Q. Are there any standards you can cite to us in terms of what sufficient clinical background a

team physician needs in terms of years of training, type of training, number of patients, anything like that?

A. No. I think there are various certificates that they would normally be able to provide. In other words, if somebody goes through a fellowship program like Dr. Williams was going through and completes it, that normally is enough to allow one to feel comfortable that he can handle routine musculoskeletal issues and -- concussions included.

On the other hand, if you're taking somebody that's been in family practice, that had one month's exposure to neurology, and then thrusting them into a situation of caring for athletes, which is different than caring for people in general because of the Return to Play issues, then I think you're going to need to have some oversight in the care they're giving, unless you're very comfortable that they have the knowledge to deliver that care.

Q. In your practice, are you familiar with what other athletic departments do in terms of staffing team physicians?

A. I'm very familiar, yes.

Q. Is there any institution that you could tell me that you're aware of that has any of their team physicians quizzed by a neurologist or another provider on their knowledge on a certain topic, or just specific to concussions, before they're put in the position of a team physician seeing student athletes?

A. I'm not aware that it's standard protocol to have Fellows treating student athletes without any discussion with a supervising physician above them. Sometimes, fellowships will allow that to happen, where the Fellow will go out and cover a high school or something like that.

But if the Fellow is -- as part of their training is covering something within the institution, a sport that then has a team physician above them, there needs to be some oversight of that individual that they're carrying out the care appropriately.

Q. And so are you saying Dr. Williams, then, let's say on the 5th, should have diagnosed a concussion, or have just been suspicious of it?

A. Either one. Either one would have been enough. He couldn't have ruled it out, and by not being able to rule it out, certainly should have

pulled the individual out and treated it as if it were a concussion. I think more probably than not, based on the SCAT scores, he should have diagnosed a concussion.

Q. And did you say -- what was your understanding as to whether Dr. Williams saw any of the SCAT tests?

A. He did not. He said he didn't.

Q. See any of them?

A. Correct.

Q. And does the treatment or what you would tell the athlete change whether you've diagnosed concussion, or suspect it, or can't rule it out?

A. Absolutely. If you can't rule it out or if you diagnose it, either way, this individual is out of sports -- would have had no further practice or game play after the 5th or the 4th, when the patient's being seen by Dr. Williams. They would not have gone from the 4th of October to the 4th of November practicing and playing games and worsening the post-concussion syndrome.

Q. So under either scenario, you diagnosed concussion or you suspected it, how long do you

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hold someone out?
A. Until they're asymptomatic or back to baseline, and have then gone through an exertional protocol and not exacerbated symptoms.
Q. Did you say that on this issue of, like, the first 48 hours after a concussion, versus up to seven to ten days -- is there some thinking that the first 48 hours -- is that the most important time to not return to that type of activity?
THE WITNESS: Excuse me. Just one second.
(Discussion held off the record.)
THE WITNESS: Sorry. Please repeat your question.
Q. (By Mr. Maynard) Is the thinking that the first 48 hours -- is that the most important time, if you have concussion or diagnose a concussion, to rest or not return to that type of physical activity?
MR. NACE: Objection.
THE WITNESS: Yeah. The point I was trying to make is that there are some people that have a concussion and the symptoms clear up in 15 minutes, and there's some people that have a concussion and the symptoms clear up in

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30 minutes. Well, it's not important whether they rested that first 24 hours or 48 hours, if their symptoms have already cleared up.
So it's not, across the board, all that important for everybody. But if you're having a significant concussion load -- significant number of symptoms and significant severity of symptoms, that first 48 hours is particularly important, as is the first week.
Q. (By Mr. Maynard) Why is that?
A. Because -- we've gone through the metabolic challenges, and we've gone through the swelling -- an axonal swelling and disruption that can occur with concussion before. And it's because of those issues that we've already gone through. I can go through them again, if you want.
Q. No, that's okay.
Is the thinking that seven days after a concussion -- well, you're saying there are patients who do rest as instructed but still can get PCS?
A. Back in 2011, most people thought that you should continue the physical restriction and cognitive restriction until the individual had

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either almost or greatly recovered from their concussion symptoms, whether that was two days, two weeks, or two months.
Now we treat concussions differently. We tend to rest them, certainly during the first 48 hours. And then we tend to start exertion at a level that does not provoke symptoms worsening, both physically and cognitively, either a week or two after the concussion.
So the treatment has changed. But back in 2011, the standard was basically physical and cognitive rest until symptoms have either returned to baseline or cleared.
Q. Are there any studies on, you know -- you had a concussion in patient A, rested them for seven days, versus patient B, who kept playing -- kept doing the same activity for seven days, but then rested?
Is there any difference in the outcomes?
MR. NACE: Objection.
THE WITNESS: No. I'm not aware of any studies that did that, but there are studies that compared individuals that started physical activity within a week of their concussion with a group that started physical activity at a

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much later period of time. And those that started much later did worse. And that's why we changed the treatment protocol to start our therapies much earlier, but only at a level that doesn't make symptoms worse.
Q. (By Mr. Maynard) All right.
Do you know Dr. Kevin Crutchfield, neurologist?
A. I do.
Q. How?
A. I've met him at concussion meetings, even on a couple of occasions where we've each presented material.
Q. I'm sorry. I missed the last part. Say again.
A. Even on a couple of occasions that I can remember where we've each been part of the faculty.
Q. Other than that, do you know him? Do you consider yourselves colleagues, friends -- social friends?
A. I don't believe we've ever gone out socially. I certainly consider him a colleague in the sense that he's in the concussion field and we have shared patients through the years.
Q. Is there anything -- have you ever read any of

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his publications?
A. Yes.
Q. Is there anything kind of in general -- I'll say a philosophy about concussions or concussion treatment with which you would disagree?
MR. NACE: Objection.
THE WITNESS: Well, I think -- yeah. I think he is much more enamored with greater occipital nerve injections and that kind of thing than I've found to be useful. But, generally speaking, I think he's certainly someone that treats a lot of patients with concussions.
Q. (By Mr. Maynard) And how would it be that you two guys would share patients?
A. There happen to be professional athletes that had seen him and then were off for another opinion.
Q. So, Doctor, I don't know if you know this, but you're going to be 80 this year. Sorry to break it to you.
Now, any plans to retire? Or are you going to keep going?
A. Well, it'll take a serious medical setback, and

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then I'll think about my retirement. Otherwise, as my wife says, the eulogy and all will happen at the same time.
Q. So at this point -- so all kidding aside, you plan to keep doing what you're doing?
A. Yes, sir.
MR. MAYNARD: Very good, Doctor. I think that's all I have. Rather than look through notes here, I'll pass it on. Thank you.
Next speaker?
EXAMINATION
BY MR. HAUGH:
Q. Okay. Doctor, I think that means that I'm up. This is Jeremy Haugh. I represent the United States in this matter.
Can you hear me okay?
A. Yes, sir.
Q. If you don't hear a question that I ask, just let me know and I'll be happy to repeat it, or at least give you a better question to answer.
A. Very good, sir.
Q. I represent the United States.
MR. NACE: Representing who?
MR. HAUGH: I'm sorry. I don't know who's

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asking the question.
MR. NACE: We're all still trying to figure out why the United States is in this case. In other words, what interest do you have that the United States represents?
MR. HAUGH: We represent the interest of the United States.
Q. (By Mr. Hock) Okay. Doctor, what is the national standard of care that you referred to in your report?
MR. NACE: Objection.
THE WITNESS: Well, I think that there isn't a document -- a single document that is put forward as standard of care. I think there are a number of documents that have been authored through the years, including, but not limited to, the 2004 and -- I don't remember the revision -- by the National Athletic Trainers' Association -- documents on concussion.
The American College of Sports Medicine has two concussion management statements. But initially -- I think it was around 2006. And then it got repeated four to five years later.
The most widely cited documents are the

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Concussion in Sport Group documents that -- from meetings that were held in Vienna in 2001, Prague, 2004, Zurich, 2008 and '12, and most recently, Zurich in 2016.
And out of all of those meetings came concussion management guideline statements, and those are the ones that are the most widely cited in the world's literature. They, alone, are not a standard of care. They are a guideline or what I would refer to as best practices.
Q. (By Mr. Haugh) Okay. So under the national standard of care you're studying, does a concussion have to be diagnosed in an athlete before they're held out of competition?
A. No. A concussion, if it cannot be excluded -- in other words, you suspect it but you can't prove it, you still hold the athlete out, just like you would if you've diagnosed a concussion. An athlete can be returned to activity if you have satisfied yourself that they do not have a concussion.
And the way you satisfy yourself of that is not by trying to say that you can't find a mechanism. So that's not a way to satisfy

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yourself of that.
Q. Okay. I'm sure we'll get to that.
So is there a specific document that I could look at, as a provider, that would tell me, "Here's what you need to do with regard to a concussion or a suspected concussion"?
A. Yeah. I would suggest the Concussion in Sport document. The most recent one is 2018. You probably don't need to go back to the previous ones.
I would go to the most recent NATA document. I would go to the most recent American College of Sports Medicine document. And the NCAA has their own document that they published in 2010 that's in their medical handbook. That's a very reasonable document.
Q. So is that the document that Dr. Williams should have looked at in 2011?
A. Well, he should have been familiar with it, yes.
Q. And does that require an athlete to be diagnosed with a concussion before they're held out? Or just suspected?
A. Suspected. In other words, you cannot exclude that they've had a concussion.

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Now, Dr. Williams did believe that he had excluded a concussion, but he based it on a faulty assumption that because he couldn't identify the mechanism, even though it was written down in black and white on that SCAT that he didn't look at that -- but because he couldn't find the mechanism, that the patient didn't have a concussion, and therefore, it's okay to keep playing. That's just, basically, very faulty.
Q. Okay. Let me ask you about that SCAT2 from October 4.
You've referred to it a couple of times, and you've said that Dr. Williams never looked at it.
Was he given an opportunity to look at it? Do you know?
A. Well, it was available. It had been filled out by the athletic trainer who referred this patient to Dr. Williams. So the document was clearly available.
Whether it was part of the bundle of information that he had when he was examining this patient -- I think maybe not. Because according to the depos, the patients were not

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seen in any office. They were just seen in the training room at the university.
Q. So if he never saw that SCAT2, would that change how he went about making his diagnosis?
MR. NACE: Objection.
THE WITNESS: Well, on the SCAT2 is written the mechanism he says he couldn't find, and, therefore, he couldn't diagnose a concussion.
He's flawed. He doesn't have to find a mechanism. But if he'd read that document, he would have found the mechanism. It's written on it.
Q. (By Mr. Haugh) Do you know if Dr. Williams is aware that Ms. Bradley had gotten hit on September 23?
MR. NACE: Objection.
THE WITNESS: I believe he was aware that she was. And I believe that she described it as a hit like she takes routinely, or at least didn't seem to be anything out of the ordinary to her.
Q. (By Mr. Haugh) So in your opinion you took into account that you thought he was aware that she had been hit in the game on September 23 on

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the head?
A. Yes.
MR. NACE: Objection.
I'm just trying to figure out if the question is was Dr. Williams aware on September 23, or was he aware before?
MR. HAUGH: Fair enough.
Q. (By Mr. Haugh) So was he aware when he saw her on October 5 that she had been hit in the head during a game on September 23? That's the question.
A. I believe he was. I could be mistaken -- that it was on a subsequent visit, but I think he was aware when he saw her. And I believe that her comment was that it wasn't an unusual hit.
Q. Okay. And did you take that -- your belief into account that he was aware of it in making the determination that he violated the standard of care?
A. Well, he violated the standard of care, in my opinion, because he said he couldn't come up with a mechanism, and therefore he could not diagnose a concussion.
What I'm saying is the mechanism was written on the SCAT. He should have seen it.

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But what is basically most flawed is that he's using he can't find a mechanism to not diagnose a concussion.

You don't have to have a mechanism. The athlete's not going to give it to you in a significant number of cases. The symptoms are going to be delayed in a significant number of cases. You're going to be able to go back through game film on a number of cases of concussion and not even pick out the blow that caused the symptoms that were reported after the game -- later that night, the next day, when the athlete eventually comes in for treatment.

Q. Okay. I understand that.

But my question was whether you took into account your belief that Dr. Williams was aware that Ms. Bradley had been hit in the game on September 23 when he met with Ms. Bradley on October 5, when you said that he had violated the standard of care.

MR. NACE: Objection.

THE WITNESS: The violation of the standard of care, as I've indicated, is saying he couldn't find a mechanism and therefore

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clearing this patient to continue to take head trauma. My recollection was he was aware that she was hit in the head, but it was my recollection that he did not read the SCAT2. Therefore, he didn't know the direct correlation that the trainer drew between symptoms and that blow to the head.

And it is true that Jennifer was not connecting the dots herself. She was not saying this was some really big hit, that immediately she had problems thereafter.

Q. Okay.

Are you aware of what Ms. Bradley's baseline score was on the SCAT?

A. She had had a SCAT baseline in which she had reported eight symptoms and a severity score of 21. And there was some discussion that she may have had some medical condition going on at that time to give her that number of symptoms and score. But, basically, that was her baseline.

So her symptom number went from eight to 17, and her symptom severity score went from 20 to 45. Each, more than doubling.

Q. Did you have an opportunity to review

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Dr. Williams' deposition?

A. Yes.

Q. Do you recall in his deposition that the SCAT2 that he saw he said was normal?

A. No. I don't remember that from his deposition. It may be there, but I don't remember that.

Q. Okay. If he did see a SCAT2 that was normal --

A. On page 113 of his deposition, I believe that he indicates on that page -- he says that he trusts what the patient tells him, and the patient was not giving him a history of the hit to the head that produced the symptoms -- that that's why he came up with that he couldn't find the mechanism.

But in that deposition on page 110, line 15, it says, "Question: Now, what you told me was that you did not see the October 4, 2011 SCAT2?"

And his answer is, "Correct."

So on lines 15 and 16 and 17 of page 110 of his deposition, he's saying he didn't see the SCAT2.

Q. Right. But he did see a SCAT2 from October 5.

Do you recall that?

A. I do not recall that, but it's possible. That

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SCAT was also quite abnormal in terms of the symptom scores and in terms of the number of symptoms -- more than double the baseline.

But it did not have that handwriting on it. That's true.

Q. Okay. So if he saw what he characterized as a normal SCAT2 on October 5, and had no indication that she had been hit in the head on September 23, would he still have violated the standard of care?

MR. NACE: Objection.

THE WITNESS: Well, let's -- I guess I'm not making myself clear, because the violation of the standard of care, in my opinion, was not that he didn't see the SCAT2.

The violation in standard of care was that because he could not determine a mechanism of injury, that this wasn't a concussion, despite these concussion symptoms happening the night of a game.

Now, it becomes more egregious, in my opinion, when he admits to not seeing the SCAT2 of 10/04/2011, in which the mechanism of injury is written on it.

But the SCAT2 of both 2004 and 2005 are

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not normal. They are grossly abnormal. The symptom score at baseline was eight, and the symptom number on the 4th is 17, and the symptom number on the fifth is 16. That's still double. That's still not normal. That's grossly abnormal.

On the other hand, the severity score at baseline is 21, it's 45 on the 4th, and it's 21 on the 5th, which is not as bad as it was on the 4th, but it's still not a normal severity score -- but not greatly different than the baseline.

So the number of symptoms was double, but the severity score wasn't on the 5th. So it's not a normal SCAT.

Q. (By Mr. Haugh) All right. I'm going to switch gears a little bit.

How did you determine that Ms. Bradley had suffered a concussion on September 23, 2011?

MR. NACE: Objection.

THE WITNESS: Because the records that were subsequently developed by the neurologist that saw her, and others' as well as her own deposition, date the onset of the symptoms to later in the day on the 23rd, and being present

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subsequently, and then eventually being brought to the attention of the athletic trainer on October 1 or 2 or about then.

Q. (By Mr. Haugh) Did you take into account that she reported being hit in the head during a game on September 23?

A. Yes, I did take that into account, but I also took into account that it was after that game, later that day, that the symptoms started.

Q. Okay. And what symptoms were those?

A. She described that she was having some difficulty with her vision -- the symptoms that she was describing were issues with vision, issues with concentration, and issues with fatigue.

Q. Do you know when those symptoms were first reported to Dr. Williams?

A. I don't think they were reported to Dr. Williams until Dr. Williams saw the patient. I think that was on the 4th of October.

Q. Okay. Yes. He saw her on October 5, 2011.

So how soon after a concussion should an athlete be held out?

MR. NACE: Objection.

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THE WITNESS: Ideally, the athlete should be held out from the time that the concussion is recognized. And the sooner it's recognized, the better.

I've already said under oath that because this athlete did not bring her problems to the medical staff until early October, I don't have a problem with what the athletic trainer did to pull her out sooner, because she wasn't being evaluated.

I do think the athletic trainer did the right thing on the 4th by getting the SCAT done to assess for concussion. And I don't have a problem prior to the 5th with Dr. Williams not having been involved with her care, because she wasn't brought to Dr. Williams.

But once Dr. Williams saw her, it's my opinion it was a deviation of standard of care to use the excuse that, "I can't find a mechanism for the concussion," to say one didn't exist.

Q. (By Mr. Haugh) How do you measure the severity of a concussion at the time it happens?

A. You don't, normally, unless there is loss of consciousness that's prolonged, in which case

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you know from the get-go that it's a severe concussion, at least by our grading scales, if the loss of consciousness is more than one minute.

But, generally speaking, you don't grade a concussion severity at the time it happens. You grade concussion severity when the symptoms have cleared and you see how long it took for the symptoms to clear.

Q. So just to be clear, a doctor would not know how severe a concussion was when they were treating a patient?

A. Not a patient that did not have a loss of consciousness. Generally speaking, you have an index of how severe it is based on the total number of symptoms they have and the severity of those symptoms.

Many of us use a symptoms checklist of 26 symptoms, each one scored one to six. So the highest number of symptoms they can have is 26, and the highest score they could have for severity would be 156.

To the extent that you had a high severity score and a high number of symptoms, you have an index that correlates and gives you a

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guideline that this patient may be going on to have a severe concussion, more likely than somebody who had a few number of symptoms and a very low severity score.

But it's only a guideline, and it's not an absolute certainty. The only way to know, truly, the severity of the concussion is to see -- in someone who was never rendered unconscious is to see how quickly the symptoms clear and you can return the individual.

Q. Just one minute please, Doctor. I think I've just one more question. We'll see if there's any follow up.

But if a person has post-concussion amnesia -- can't remember a hit, would they recall it at any future time? Or is it lost forever?

A. They might --

MR. NACE: Objection.

THE WITNESS: -- and they might not. Both scenarios happen.

Q. (By Mr. Haugh) In what cases might they remember it?

A. When their memory comes back, and they no longer have any retrograde amnesia, and they

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can remember things right up to the point of concussion. And that normally, if it's going to happen at all, would happen when all the other symptoms went away as well.

Q. And when you say, "All the other symptoms," you mean -- do you mean the concussion symptoms, or post-concussion symptoms, or both?

A. Both. The normal thing that happens when somebody has amnesia for events prior to the hit to the head -- so you're not going to remember being hit in the head -- is that those events, in a pretty severe concussion, might be a day or two or hours. And then over time, as they're getting better, that time shortens.

Whereas they used to not be able to remember what happened that morning, the morning comes back. And then it gets closer, and closer, and closer to the point their head was hit.

And then if they get complete memory back, they'll even remember the hit, but not in every case.

Q. I did -- I forgot I do have just a short area of questioning that I want to add.

You had written -- and I believe Dr.

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Higgins' counsel asked about this, but I want to ask a little bit more specifically.

You write that Dr. Williams didn't demonstrate a sufficient clinical background to be left in sole control of making that concussion diagnosis.

What is the proper background for being able to make a concussion diagnosis on your own?

MR. NACE: Objection.

THE WITNESS: Well, at the very most elementary level, you would have to know what concussion symptoms are, and what assessments you're going to use to assess for the symptoms and assess for the signs that may be present after a concussion.

But also consistent with that is it would be elementary to understand you don't have to know the mechanism, meaning you don't have to be able to identify the particular blow to the head that caused the concussion, for a concussion to be suspected, if not diagnosed.

MR. HAUGH: Okay. Doctor, thank you. I don't believe I have any other questions at this time. I know some other people may have

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follow-ups. Thank you.

THE WITNESS: You're welcome.

MR. MURPHY: Will, I think you're up.

MR. STUTE: Okay. Sounds good.

EXAMINATION

BY MR. STUTE:

Q. Doctor Cantu, my name is Will Stute, and I represent the NCAA in this matter.

Dr. Cantu, do you know what the NCAA is?

A. Yes. Yes, sir, I do.

Q. What is it?

A. It's an organization that was founded to protect the health and safety of student athletes. National Athletic Association.

Q. And, Dr. Cantu, do you have any opinions at all with respect to the NCAA in this matter?

A. No. I think their handbook that was done in 2010, following the National Football League, proclaiming that anybody suspected of a concussion or diagnosed with a concussion needed to be immediately removed from a contest was very appropriate. And I think mandating schools to be responsible for developing a written concussion management protocol was meritorious.

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Q. Let me ask you one follow-up question on that, Dr. Cantu.
Do you believe that that document you referenced, the handbook that came out in 2010, was state-of-the-art at that time with respect to concussions?
MR. NACE: Objection.
THE WITNESS: I think it was pretty close, yeah, in 2010.
Q. (By Mr. Stute) What does, "Pretty close," mean?
MR. NACE: Objection.
THE WITNESS: I don't want to say that it was perfect, but it certainly was very good and very appropriate for 2010.
MR. STUTE: Thank you, Dr. Cantu. That's all the questions I have for you at this time.
THE WITNESS: You're welcome.
EXAMINATION
BY MR. NACE:
Q. Doctor, I have a few questions I wanted to follow up on while I'm up here. Counsel will have their shot.
Just looking at your expert designation, page four, where it's written, "Within a

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reasonable degree of medical certainty, had the standard of care been followed, Ms. Bradley's symptoms would have resolved naturally within ten to 14 days, and she would not have developed a very severe, protracted post-concussion syndrome" -- is that your opinion after all the stuff that we've talked about today?
A. Yeah. That's my opinion.
Q. And my question also is, on the ten to 14 days, that's from the onset of symptoms?
A. Well, it's technically from the onset of symptoms. And it's true that part of that time she's not bringing those symptoms to medical personnel, and so I'm not holding any medical personnel, including athletic training, responsible for not knowing something that wasn't brought to them.
Q. Right. And you had mentioned you were looking at the SCAT2 test of 10/04. That's BATES stamped number 11,004, where it says, "Listed dizziness after getting shoulder to head. Whole week after, felt fine."
And so the symptoms that we're talking about, they did not originate the day of the

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incident. She had a whole week feeling fine without symptoms; correct?
A. If that history is accurate, that's what it suggests.
MR. MURPHY: For the record, this is John Murphy.
I'll object to the foundation.
Q. (By Mr. Nace) And, then, also, you were talking a little bit just recently about what was relayed. And you were provided the records from American University and the injury records, SportsWare, which you should have as page 10,000. It goes in reverse order. But 10,030 to 10,033.
Now, 10,032 on 10/05/2011, that says, "Athlete approached me after game with her mother on 10/02 saying she has been having difficulty with her vision while playing, an increase in fatigue, and getting dizzy while playing. Athlete says she's been experiencing that for about two weeks. Athlete has history of hypoglycemia, moderate to low blood pressure. I asked if she remembered being hit in the head on the game.
She replied, quote, 'I mean, nothing worse

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than usual. I got hit in the head by some girl's shoulder, but I get hit like that all the time. I didn't think that it was anything significant.'
Athlete did not -- end of quote -- athlete did not notify me of being hit or complain of any symptoms following."
So on 10/05 she's reported the hit to the head, but not only on the SCAT2 test, but also in the medical record of American University; correct?
A. Yeah. Those BATES pages don't correspond with mine, but what you read just then, I remember having read verbatim.
Q. And it's your opinion that standard of care required Dr. Williams to know what this mechanism of injury was?
A. No.
Q. No. Okay.
A. No. No, my opinion is that because he couldn't establish a mechanism, that was no reason to exclude concussion as possibly occurring here in this case. That's the deviation of standard of care. He's using something that can't be used to exclude concussion.

Now, I said it was compounded by the fact that the mechanism was there if he wanted to dive in and find it. On the SCAT2, it's written down.

But the deviation in standard of care is the -- using that he couldn't find one as a reason for not excluding or suspecting concussion.

Q. My question is really that it's documented twice in the record -- that he could have found it if he wanted to; correct?

A. Yes, it's true. It is in the record. It is in the record.

Q. And, then, this is the other question that I have.

We were talking about the SCAT2 that you referenced -- the tech five SCAT2 that had total symptoms, 16, severity of symptoms, 21 --

A. Yes.

Q. -- and that was done at 6:00 a.m. on -- BATES stamp 11,008.

I don't think you have discussed the one -- BATES number 11,012, which was done 10/05 at 11:00 a.m., with a total number of symptoms, 19, and the severity score of 40.

Is that a normal SCAT2 test?

A. Neither one is normal. The second one is much more abnormal.

MR. NACE: Okay.

That's all I have, Doctor.

John, did you have anything more?

MR. MURPHY: I don't have any follow up, Doctor.

Just the one thing I'd ask is -- we're still -- discovery is ongoing in this case. So should you review anything else and your opinions change in any significant way, notify us of any change in your opinions; fair enough?

THE WITNESS: Yes, sir.

MR. NACE: And, Doctor, before we cut off, I just wanted to say for the record, you are provided payment for this deposition as Plaintiff's counsel on behalf of -- a quarter of that on behalf of the Government.

I understand the Government's going to get that to -- Jeremy, is there a way that we're going to process this?

MR. HAUGH: Yes. If I can just get an invoice, I can process it. That's it.

If you can e-mail me an invoice for my

portion of it -- or the Government's portion of it, I should say, then I can get it processed.

MR. NACE: Okay. Well, that's an exhibit -- going in with the exhibits that we got from you. The last standard e-mail I sent to you is the fee schedule for the deposition that was split four ways.

MR. HAUGH: Okay.

(The deposition concluded at 4:28 p.m.)

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ROBERT CANTU, M.D.

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I, Molly K. Belshaw, a Notary Public for the State of Massachusetts, and Registered Professional Reporter, do hereby certify that the foregoing is a true and accurate transcript of my stenographic notes of the proceeding taken at the place and on the date hereinbefore set forth to the best of my skill and ability under the conditions present at the time.

I further certify that I am neither attorney or counsel for, nor related to or employed by any of the parties to the action in which this proceeding was taken, and further, that I am not a relative or employee of any attorney or counsel employed in this case, nor am I financially interested in this action.

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JENNIFER BRADLEY
Plaintiff
vs. Case No.
1:16-CV-00346
NCAA, et al
Defendants

Deposition of WILLIAM VOLLMAR, M.D.
Quarryville, Pennsylvania
August 20, 2018
1:00 p.m.

Pages: 1 - 136
Reported by: Pamela J. Dogger, RPR

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DEPOSITION of WILLIAM VOLLMAR, M.D. at:
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Quarryville, PA 17566

Pursuant to Notice, before Pamela J. Dogger,
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Notary Public of the Commonwealth of Pennsylvania.

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PROCEEDINGS

WILLIAM R. VOLLMAR, M.D.,
having been duly sworn, testified as follows:

EXAMINATION

BY MR. MURPHY:

Q Good afternoon, Doctor. Please state your full name for the record?

A My name is William R. Vollmar, M.D.

Q Have you ever had your deposition taken before?

A Yes.

Q About how many times?

A Two. Two maybe.

Q Okay. I know you have some familiarity with the process. I'm going to be asking you some questions about your opinions in this case because we are doing this by video conference today and there is a slight delay, so it's important that you let me finish my question before you give your answer, and if I

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accidentally interrupt you before you gave a complete answer to any of my questions, put your hand up so I can see it as well hear it so I can stop and extend the same courtesy to you. Okay?

A Yes. Thank you.

Q I do need verbal answers to all of my questions, as opposed to nodding of the head. If you don't understand any of my questions, please let me know and I'll be happy to rephrase it. Okay?

A Yes.

Q And then if you need to take a break, if you need to take a break at any point, Doctor, just let me know that as well.

A Okay.

Q Can you tell me a little bit about your current practice? I know it's sort of a sports medicine and family medicine practice, as I understand it from your CV. Kind of explain to me what you do on a weekly basis?

A I am Boarded in both family medicine, as well as an additional primary care sports medicine, and on a weekly basis I do family practice, routine from

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wound-to-tomb family practice, and then I also have a sports medicine practice, where I cover local schools. I work for the State, the PIAA, and do competitions and oversight. I go to schools and see kids for athletic injuries on a regular basis, and that's what I do.

Q So, when you are in your physical office, is that only family medicine and then your sports medicine practice is when you are going out into the community?

A No. I have sports patients in the office as well. My practice is probably about 70 percent sports medicine, 30 percent family medicine at this point.

Q And how often are you going out to various schools to either see students in the school setting, or overseeing sporting events?

A At least two to three times a week.

Q It looks like from the CV that I have that you are a team physician at a number of area high schools; is that correct?

A That is correct.

Q Have you ever been a team physician higher

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than the high school level?
A I take care of some people from colleges, but I am not officially any college's team physician.
Q And how many high schools are you currently affiliated with?
A Five. For sports, five.
Q Have you ever been a team physician for a high school women's field hockey team?
A Yes.
Q And at what high schools have you been the field hockey team physician?
A All of my high schools have field hockey as a sport, so it would be all of them.
Q The schools that you are the team physician for, are you the only team physician or do they have a group that does that?
A I am the only team physician.
Q Can you give me an idea as to how often you are treating patients, at least with concussions?
A Frequently.
Q Is it a weekly occurrence?
A Oh, yes. It's sometimes a daily occurrence, depending on what's going on.

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Q How many -- or tell me how much experience you have with post-concussion syndrome, and let me kind of get your own definition physician first. When does a concussion turn into a post-concussive system? Is there a timeline or how does that work?
A That is a debatable issue at this point from the literature. Post-concussion was originally defined as anything that occurred six weeks after a concussion. Some people have then gone out to three months and six months.
My idea of a post-concussion syndrome is anything that lingers on for an extended period of time. I do not use a specific timeline. The only timeline I do use is that when people have symptoms beyond a year, I think we're dealing not with a concussion or a mild traumatic brain injury, but we're dealing more into the moderate traumatic brain injury realm since we're looking at more permanent deficits.
Q So then using your definitions that you just gave me, I'm trying get a sense. I know you told me you see concussions weekly, if not daily basis. How many patients are you seeing for post-concussion syndrome?

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A Actually, I have two right now.
Q And then how often are you treating patients with moderate traumatic brain injury?
A I have three or four in my practice. Some of them are not athletes, some of them are just regular patients.
Q The patients that you are treating now with post-concussion syndrome, were they all held out of athletics once they were diagnosed with concussion?
MR. NACE: Objection.
You can answer.
THE WITNESS: Those that are in athletics would probably have been held out. Those that are in athletics now are held out. The other ones were adults who received them from accidents or those issues. There was nothing to hold them from. Well, they can't work, but that's about it.
BY MR. MURPHY:
Q Got it. Okay. And I don't want you to give any patient-identifying information for HIPAA purposes, Doctor. I'm just trying to get a general sense.

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For the athletes that you have cared for, have you had athletes with post-concussion syndrome, even if they were held out from day one with a concussion occurring?
A Yes.
Q How about the same thing for athletes with moderate traumatic brain injury. Have you had those athletes where concussion were diagnosed promptly, they were held out of practice, sporting events and they still went on to develop moderate traumatic brain injury?
A Yes.
Q Have you published at all with respect to concussions?
A No.
Q Doctor, are you going to be rendering any opinions against the athletic trainers at American University in this case?
A I have no specific opinion except for what I have read in the deposition reports.

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MR. MURPHY: And Matt, you can feel free to help me out. I don't want to go into a whole bunch of questions about athletic trainers if he's not going to render any opinions against them.

MR. NACE: I think his testimony is going towards Dr. Williams. I think he's going to speak to what Jen did, but I think you've got to ask him the questions. Sorry. We gave you a pretty detailed report, I thought.

MR. MURPHY: I'll go into it in a little greater detail then.

BY MR. MURPHY:

Q Doctor, have you ever supervised athletic trainers?

A Yes.

Q In what capacity?

A In Pennsylvania, all athletic trainers have to have a physician as a supervising physician. At all my schools, I am the supervising physician.

Q Do you know if it's that way in the District of Columbia?

A I don't know, sir.

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Q In your role as supervisor of athletic trainers, other than being available for them to ask you questions, what other sort of responsibilities do you have specific to athletic trainers?

A Standing orders for athletic trainers within the school.

Q What do you mean by that?

A Can they give Tylenol, can they put on a Band-Aid?

Q Got it. Do you do any sort of training for athletic trainers?

A I do teach, yes.

Q And tell me about your teaching of athletic trainers.

A I teach, actually, at multiple levels, but my athletic trainers are taught when I am on scene or when they come to conferences that I'm involved in. I teach medical students, residents, and physicians as well.

Q With respect to teaching of athletic trainers, you mentioned conferences a minute ago. What conferences have you been to lately where you're

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teaching athletic trainers?

A I teach for a group called Continuing Medical Education. That takes me all over the country. I teach for the hospital that I am the sports medicine coordinator for the residency at Lancaster General Hospital, and I teach in the community when trainers are requesting education.

Q Have you done any specific courses on concussion management or concussion protocols?

A Yes.

Q And through what group was it? Was it just the one you just mentioned a minute ago?

A I have talked to many of those groups I have done a concussion lecture to.

Q Have you put together any actual training materials or done any actual online presentations for concussion management for athletic trainers?

A Not online. No. I mean, lecture materials like PowerPoint, that kind of stuff. Yes.

Q And you have done that?

A Yes.

Q Do you still have copies, PowerPoint

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presentations? I'm really -- I'm being very specific here about concussion protocols, the concussion management that was put together for athletic trainers?

A I have. I use the same lecture for physicians as I do for athletic trainers, so, yes, I have that material.

MR. MURPHY: Okay. Matt, depending on how far we go with opinions, I may ask for those, but let's just see where we get.

BY MR. MURPHY:

Q You don't hold any certifications as an athletic trainer; is that correct?

A I do not.

Q Have you ever published anything specific for athletic trainers in the athletic trainer journals or anything like that?

A I have not.

Q On the CV that I have for you, it looks like your team physician experience started in '92; is that correct?

A That's correct.

Q Do you know when in Pennsylvania athletic

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trainers had to fall under the supervision of a physician? In other words, was that all the way back to '92, or something more recent?

A No. I don't remember the time, but I know it was after '92.

Q And I'm not going to quote you on a year, but can you give me a ballpark idea it was?

A I would think it was probably in the early 2000s.

Q Do you attend any conferences specifically for athletic trainers?

A I tend to go to physician conferences, yes.

Q Well, I would assume that you went to the physician conferences, but I'm trying to figure out the National Association of Athletic Trainers, do you go to their annual conference or conferences?

A I have not. I go where the credits flow.

Q Have you done any specific seminars for athletic trainers at the NCAA level?

A No.

Q Have you been involved in developing concussion protocols at any of your high schools?

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A Yes.

Q Have you reviewed the concussion protocols in this case for American University?

A I was not given any protocols by American University.

Q That's fine. Is it fair to say that you're not going to render any opinions that American University protocols violated accepted norms and standards?

MR. NACE: Objection.

You can answer.

THE WITNESS: Yes. I have a question on my ability there, because this concussion occurred in 2011 and it was in 2009 I believe that the first consensus -- international consensus on concussions came out and many people had not transferred over to the new guidelines for several years, so I don't know what their protocol was. I know they were using the SKAT, which is an accepted measure of cognitive and concussion symptoms, but it is not a diagnostic tool.

So beyond that, I can't answer. Everything in concussions changed with the first consensus, international consensus conference, from what it was before.

MR. NACE: John, to save you a question regarding the actual written policy that's been produced, he's not going to speak to the actual written policy that you guys have produced. I'm assuming you want to know is there a problem with that written policy, and he's not speaking to that.

MR. MURPHY: Okay. Thank you, Matt.

BY MR. MURPHY:

Q Doctor, do you have a copy of your expert report handy? The report you signed. I didn't bring a copy.

MS. ROUTH: I've got a copy, John.

MR. MURPHY: Thank you.

BY MR. MURPHY:

Q And I'm referring to this to try to speed it along, Doctor.

Do you have what's titled Rule 26 (A) in front of you?

A Yes.

Q If you look at Page 3, Doctor, do you see where it lists out all the records and information that you reviewed?

A Yes.

Q My first question is looking at that list under Section 2 Data Considered, have you had an opportunity to review all of those records as well as the deposition transcripts listed?

A I have reviewed records from Dr. Bentz. I have seen the AU Concussion Baseline Tests. I don't know what emails were provided by the client. I do not have anything from Washington -- I have not reviewed anything from Washington Ear, Nose and Throat. I do not have -- I have not reviewed anything from Brain Wellness and Biofeedback of Washington, National Rehabilitation Hospital. I have reviewed lab results. I have reviewed x-ray results. I have never had anything email-wise from American University, and I have nothing from Georgetown.

Q Okay. How about the deposition transcripts listed? Have you had a chance to review all any of those?

A I have gone through them briefly. You

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present an enormous amount of information for casual reading.

Q Okay. Fair enough. Other than what you just told me from this list, because I know this report was prepared some time ago, have you been provided any additional records not reflected on Page 3 of the report?

A I have no additional records. No.

Q The athletic trainer, Sean Dash was deposed and the coach of the field hockey team, Coach Jennings, you never got those deposition transcripts; is that correct?

A I have to look through my deposition book given by Mr. Nace, but if they are in there, I have only cursorily gone over them, because he was not the trainer that I got the SKAT reports from. That was a female trainer, and that's where I reviewed the SKATs.

Q Okay. One of the plaintiff's experts in this case is a Dr. Cantu. Do you know Dr. Cantu?

A Yes. He is the grandfather of concussion medicine in this country.

Q I thought you might know him. Have you had

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a chance to review Dr. Cantu's deposition testimony?

A I have not.

Q I assume you had or you hold Dr. Cantu's opinions in high regard based on what you just said a moment ago?

A I do.

Q Have you been provided copies of the plaintiff's school transcripts?

A If I have them, I have not seen them.

Q How about any of her social media? She's got a pretty active social media presence?

A I have no social media from the plaintiff.

Q Okay. I guess I don't want to get too far ahead of myself, but just from a background standpoint. Are you critical of any care and treatment that was rendered by Jenna Earls, the athletic trainer in this case?

A I believe Mrs. Earls is the person who did the original SKAT and the follow-up SKAT, and I appreciate that she did those things. What she did with that information, I am not familiar.

Q Okay. In light of the fact that you're not

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familiar with what she did with the S KAT testing are you going to render any opinions that she was in any way negligent in this case?

A I can't render an opinion except that the SKATs changed.

Q Okay. And I'm assuming that you're not rendering any opinions against the coach of the field hockey team, are you, Doctor?

A I wrote a letter to the coach of the field hockey team. My opinion in there is quite clear.

Q And that opinion was essentially that she should be held out of all management responsibilities, all athletic responsibilities and maintain her scholarship; is that correct?

A That is correct.

Q But you're not going to render any opinions that Coach Jennings did anything wrong with respect to coaching Ms. Bradley in this case, are you?

A I have no opinion.

Q Doctor, let's talk a little bit about your factual understanding of the events in this case and let me start with the plaintiff. How many concussions

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are you aware of her having received over her lifetime?

MR. NACE: Objection.

You can answer, Doctor.

THE WITNESS: The only one that I'm aware of is the one that she received at American University under -- while playing field hockey in September of 2011.

Q Well, have you reviewed any of Ms. Bradley's medical records that predated the September concussion?

A The records that we have in our possession, I have, and I don't have any other information on concussion.

Q Okay. I guess what I'm trying to understand, did you have any understanding of what Ms. Bradley's health history was like prior to September of 2011?

A My understanding from my records is that she was very healthy.

Q Are you aware of her ever having any problems with fatigue, vertigo, headaches, anything like that prior to September 2011?

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A By her report in my records she had not had those before.
Q I'm assuming that Ms. Bradley reported to you that she began to have problems with a concussion-like symptoms after a Richmond field hockey game on September 23rd, 2011. Is that your understanding?
A That is my understanding.
Q And when did -- well, what symptoms did she develop and when did she develop them in relation to that Richmond field hockey game?
A She reported that with the hit, she did not realize much of anything because she's used to being bounced around in college level field hockey, which is normal, but that within two to three days, she was starting to have headaches, dizziness, difficulty with concentration, generally not feeling well, loss of energy. Those were the issues that I recovered from her in history of this event.
Q When did she report those problems to anyone, any healthcare provider or anyone at American University?

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A My understanding is that she had spoken to the trainer, the female trainer that you had mentioned, and the first SKAT was done within a week or so of her injury, if I recall correctly.
Q Okay. Did you see any emails that the plaintiff wrote to the trainers identifying what problems she was having?
A I have not seen any emails.
Q Okay. In your experience what is the critical time period following a concussion for a student athlete to rest and try to recover from that concussion?
MR. NACE: Objection.
You can answer.
THE WITNESS: There is no specific time period as Dr. Cantu has probably noted to, and as the Conference in International Concussion Consensus has stated, everybody's resolution to a head injury is genetically determined and is individual. We do things based on resolution of symptoms and able to progress into activity again without recurrence of symptoms.
BY MR. MURPHY:

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Q And I appreciate that, and I'm sorry, it was a poorly worded question. I think we missed each other there.
Is there any recognized time period for which it is critical that an athlete stay out of practice once they are being symptomatic?
A Again, I'm going to say it depends on the athlete's symptoms. There is no they must stay out for a day rule, they must stay out for a week rule. Those rules tend to be avoid any stimulation while the athlete is still having symptoms.
Q Would you agree with me that the first seven to ten days is typically the most important period, not to say that they may not need to stay out longer, but the initial window of a week to ten days is the most important time frame?
MR. NACE: Objection.
THE WITNESS: I cannot state that.
BY MR. MURPHY:
Q Okay. If there is a delay in the athlete reporting signs and symptoms of a concussion, can that cause any harm?

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MR. NACE: Objection.
THE WITNESS: Any delay in diagnosis delays the athlete's ability to recover as quickly as possible.
BY MR. MURPHY:
Q The first SKAT test I believe was, I think, October 4th. Give me one second. Yes. I believe the first SKAT test was on October 4th. Do you have any idea how many games or practices Ms. Bradley participated in between the Richmond game on September 23rd, and that October 4th SKAT test?
A I do not.
Q Do you know when the plaintiff first participated in any athletic event or activities after the October 4th SKAT test?
A I do not.
Q Do you know if the plaintiff was held out of any athletic events or athletic participation for any period of time following the September 23rd incident?
A By my review of my records, and a few of the trainer's records, I have no indication the athlete

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was held out.
Q I do not represent any of the physicians in this case, so I'm going to let their attorneys ask questions about them, but from a factual standpoint, is it your understanding that the plaintiff was seen by the team physician, Dr. Williams, on October 5th?
A Yes.
Q And I'm assuming if Ms. Earls did the SKAT test on October 4th and she had the student athlete be seen by the physician the next day, you don't have any problem with that; correct?
A At that point, no.
Q Do you know what, if any, healthcare providers also saw the plaintiff in that October 2011 time frame for some of her complaints consistent with a concussion?
A I do not. The only ones I'm familiar with are the trainers and the team physician.
Q And you told me you have not seen the records from Georgetown Hospital; correct?
A I have not, that I can recollect.
Q Okay. Do you recall seeing any records

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from an ENT down in the Maryland or DC area in October of 2013?
A I know she saw somebody. I do not have the records.
Q Do you have any idea what that healthcare provider did for her; diagnosed her with?
A I think they were looking for sinus issues, based on what she had told me, but I kind of thought that was a poor choice of differential diagnosis to pursue.
Q You're not going to render any opinions against an ENT in this case, are you?
A I am not.
Q Do you know if the plaintiff was referred to a neurologist back in the October 2011 time frame?
A I do not know that she was referred to a neurologist.
Q If, hypothetically, someone -- one of her healthcare providers had referred to plaintiff to see a neurologist in October of 2011, is that something that you would have agreed with?
MR. NACE: Objection.

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THE WITNESS: Not knowing the neurologist, I find that neurologists are often not as familiar with seeing athletic concussions, as other people who provide their care, so I don't often hold solid a neurologist's opinion on a concussion because they are not as familiar with the athletic environment.
BY MR. MURPHY:
Q So do you ever refer student athletes with concussive syndrome to a neurologist?
A I do not.
Q When you are treating a student athlete with a concussion, or one that's developed into post-concussion syndrome, as you defined it, do you ever refer them out to someone else to manage their problems or do you always manage them?
A I manage them.
Q When the -- strike that. Throughout the fall semester of 2011, when the plaintiff came home for her Thanksgiving break, do you know if she saw any healthcare providers up in Pennsylvania?
A I do not recollect.
Q How about when she came home for the

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Christmas break time frame in 2011, do you know if she saw any healthcare providers up in Pennsylvania?
A I think the first time she notified us was in January of 2012.
Q Do you know how she got to you?
A I think somebody may have recommended us because of our sports medicine background.
Q But you do not know who?
A I do not.
Q And when she came to your practice -- we'll get into the notes in a few minutes, but when she came to your practice in January of 2012, she had already been diagnosed with a concussion at that point; correct?
A I believe they had come to the conclusion that she had had a concussion.
Q Do you know if at any point during the fall 2011 field hockey season the plaintiff had sustained any subsequent head traumas after the Richmond game, what is sometimes referred to as second hits?
A I do not know of any second hits.
Q You are familiar with that term; correct?

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A It's not one that we would tend to use medically. We would use the idea that she had another concussion during that season.
Q Okay. Then I'll use your terminology, I'll ask a better question.
To your knowledge, did Ms. Bradley ever sustain any additional concussions that fall 2011 season after the Richmond game?
A Not that I am familiar with.
Q Once the plaintiff was diagnosed with a concussion, do you know if she ever returned to athletic practice or any athletic involvement with the team?
A I am unfamiliar with any athletic involvement after diagnosis of the concussion.
Q Do you know when the plaintiff stopped going to or taking classes at American University?
A I know she didn't go -- I know she didn't go back for the spring of 2012.
Q It's my understanding that she enrolled in classes and went for a period of time in the spring of 2012, but didn't complete the semester. Is that your

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understanding as well, or do you think she sought no classes?
A I think she may -- this is going back a long time. I think she may have tried, but was unable and had to withdraw.
Q Do you know if she went on any spring break trips in March of 2012 for that spring semester?
A I am unfamiliar with any trips.
Q I think I know the answer to this based on a prior answer, but do you have any idea how she did academically once she did return to school?
A Once she returned to school in 2012?
Q Well, do you know when she returned to school?
A I am not completely clear, because I heard she had failed all of her classes the one semester.
Q Okay.
A So, I thought that was when she eventually withdrew and we sent a letter for relief and consideration of head injury and that was in 2012, so she must have gone back 2012, because that's when I sent the letter saying we're asking for relief of

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grades because of her head injury.
Q Regardless of when she returned to school after the spring 2012 semester, do you know how her grades were or what she did academically at that point forward? Academically that point forward?
A I'm not understanding your question, sir. I'm not understanding the timeline of your question.
Q Are you aware that Ms. Bradley graduated from American University?
A Yes.
Q From whatever the date was that she returned to school post-concussion until the date of graduation, do you have any idea how she did academically during that period time period?
MR. NACE: Objection.
You can answer.
THE WITNESS: I don't have the specific grade point average, but I understand that she did fine.
BY MR. MURPHY:
Q Okay. With respect to opinions you may have as to the athletic training staff, you told me that

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you're aware Ms. Earls did two SKAT tests and you have no problem with that. That was appropriate to do a SKAT test; correct?
A Correct.
Q And you told me that you have no problem with her having the student athlete be seen by the team physician on I believe it was October 5th; correct?
A At the delay, based on the report, the date of the head injury at that point in time, she ended up seeing the physician 24 hours after the SKAT test, was acceptable.
Q Okay. Do you have -- well, is it your understanding -- let me rephrase the question. I'm just trying not to tread on other counsels' toes here.
What is your understanding as to the diagnosis by Dr. Williams on October the 5th?
A I honestly believe he reported sinusitis. No evidence of concussion, because he did not think there was a mechanism of injury.
Q Okay. I'll let other counsel ask you questions about Dr. Williams, but from the point that the plaintiff saw Dr. Williams going forward, do you

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have any criticisms of Ms. Earls or anyone else at the training staff at American University?
A My only criticism is the delay it took to get that first SKAT test done.
Q And can you quantify for me how long that delay was? In other words, what is your understanding as to when the symptoms were reported and when that SKAT test was done?
A My understanding is the symptoms are reported within three to five days of the injury. The SKAT test should have been done then.
Q If hypothetically the symptoms were first reported to the training staff on a Sunday evening after a game. Monday the team had off, and then the SKAT test was done Tuesday morning, October 4th. Under that high hypothetical timeline, would you have any problems or criticisms of that delay?
A Personally, I would be critical of that delay. The SKAT test should have been done when the symptoms were reported.
Q Okay. Do you have any idea what, if any, activities the plaintiff participated in between when

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she first reported the symptoms until when she was seen by Dr. Williams, or actually until she was seen -- the first SKAT test was administered?
A I do not have any idea of what she participated in except to say that she was not held out.
Q If I'm following you correctly, your criticism so far as it relates to the athletic trainer, is that she could have been more prompt in administering the SKAT once these symptoms were reported to her. Is that fair?
A That is fair.
Q And that is the extent of your opinions as far as the athletic trainers are concerned; is that fair?
A That would be fair.
Q Okay. All right. Let's go through -- do you have your actual patient notes with you, Doctor?
A I do. Can I open my computer?
Q Absolutely.
A I have her records in front of me, sir.
Q All right. Before we get to them, just a

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couple real quick general questions. Would you agree with me that when managing concussion symptoms it is important for a patient to timely report her symptoms to the healthcare providers?
MR. NACE: Objection.
THE WITNESS: If the patient has knowledge of what a concussion is, it is important that they have a timely giving of that information to a healthcare provider.
If the patient is unsure of what those symptoms are, I can't answer the question.
BY MR. MURPHY:
Q Okay. But what is your definition of a patient timely reporting signs and symptoms -- start over again.
You said it's important to timely report and I just want to know what is your definition of timely reporting the signs and symptoms consistent with the concussion assuming the student athlete knows what they are?
MR. NACE: Objection.
THE WITNESS: As soon as they have the

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symptoms, they should be reported.
BY MR. MURPHY:
Q All right. Going now to your practice notes, if I am following these correctly, the patient was first seen by a Dr. -- is it Geidel?
A That is correct.
Q I am not familiar with Dr. Geidel. Does he have the same sports management background that you have?
A No. He is Boarded in family medicine and sports medicine also.
Q And as I'm looking at his report, the examination he does of the plaintiff as I'm looking at it appears to be essentially normal. So my question is, I know you weren't the one that did the exam, but based on his report, do you see any abnormal objective signs documented?
A I do not see any abnormalities in what he reported for exam.
Q Is that unusual to have someone with post-concussion syndrome have a normal examination?
MR. NACE: Objection.

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THE WITNESS: A normal physical examination would not be unusual in somebody with post-concussion syndrome.
BY MR. MURPHY:
Q How about a normal cognitive evaluation?
A I do not see a lot of cognitive evaluation here because there is no mention of memory testing in this note.
Q If you are looking at what is my Page 2, right above Assessments, it talks about cognitive functioning. Do you see that?
A Correct.
Q And then there is a whole bunch of things that are talked about as being normal. Are those cognitive tests that you typically do for your patients?
A I consider cognitive testing brain procedural testing. These tests are more a balance and nervous system testing. My cognitive testing generally comes from the mini mental status exam, which is give three words and ask them what they were five minutes later. Do months of the year backward. That kind of

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stuff. That is my general line in cognitive testing.
Q Do you know if any of that was done on July 5th, 2012, the initial patient visit?
A Based on this note, I cannot say it was. I would hope they were, but yes, I can't say it was.
Q Assuming they were done, if there were any abnormal findings, would you expect that Dr. Geidel would have documented it?
A Yes.
Q Since you hoped that they would have been done and presumably that's the practice that's typically done up there, is it your interpretation of his note that they were done and they were normal?
A I'm not going to interpret something I can't read.
Q Okay. I believe Dr. Geidel saw her a handful of times and then you first saw her on December 27th at 2012; is that correct?
A That is correct.
Q Why did she switch from Dr. Geidel to your services?
A That actually may have been the time

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Dr. Geidel left our practice.
Q Other than him leaving the practice, was there any other reason why you assumed Ms. Bradley's care and treatment?
A I am the only person in the practice with the sports medicine training.
Q Once Dr. Geidel left?
A Yes. The other providers are strictly family medicine.
Q Got it. All right. So then on your initial visit do you see the chief complaint at the top of your report?
A Yes.
Q Who is the individual that took the chief complaint history from the plaintiff?
A He was a medical assistant in our practice.
Q And what is his first name?
A Mike.
Q And I'm assuming that is fairly typical practice for the medical assistant to get the history and he puts it in the record?
A He just takes the chief complaint. He does

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not take the history.
Q Okay. So then you come in and you see the patient for the first time; correct?
A Yes.
Q And under history of present illness, a lot of the language is identical to what Dr. Geidel had in the report when he first saw the patient. My question is, I'm just trying to understand your system, is it auto filled from the last visit and just make changes, or how does that work?
A We can auto fill from the last visit and make changes or we can add to the auto fill. It depends on the provider what happens.
Q To the extent that language may be identical from the prior visit, does that suggest that it was an auto fill and where there's differences, that that was the part that was changed?
A Probably.
Q Under your History section you talk, and it's the last line, about the plaintiff reporting short-term memory problems.
Do you see that?

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A Yes.
Q Are you aware of her having reported short-term memory problems at any time prior to you seeing her on December 27th?
A I am not aware, as this is the first time that I was seeing the patient.
Q I did not see it mentioned in Dr. Geidel's notes at all. Did you see any reference in any of your records that you had prior to December 27th to her having short-term memory problems?
A The only reference that I have to short-term memory problems is the increase in the SKAT score over the time of the diagnosis at American University when the score went from 7 to like 18, or something like that. That would suggest a cognitive deficit.
Q Do you know what, if any, memory problems the plaintiff was having in between when the last SKAT was done and then when she sees us in December 2012, over a year later?
A Only that I heard that she didn't do very well in school in the semester of 2011, the fall 2011.

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Q Did you do a mini mental on this visit?
A Yes, I did. At the bottom of my exam I talk about a negative Romberg, which is a central test for balance, and then mild difficult with short-term recall remembering two out of three words as instructed. That would be part of my mini mental status exam. The rest of the exam must have been reasonably normal or I would have reported all of it.
Q So what is the negative Romberg? What is that?
A A Romberg is a central balance test. When we look at balance, we have them stand, they put their arms out, palm up, close the eyes, and we watch for changes in balance.
Q And by negative, does that mean her Romberg exam was normal?
A That is correct.
Q I'm used to seeing mini mental tests. Do you ever use the mini mental tests?
A No. I check my own memory by giving the test from memory every time.
Q Okay. Other than giving her three words and asking her five minutes later what they were, was there any other type of mini mental testing done on the plaintiff?

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A Yes. That's the positive finding. My mini mental status is give three words, do a neurologic exam as a distraction, ask the patient their birth date and then to go backwards from their birth date, through 12 months of a year. That has to be accomplished within 30 seconds with no more than one mistake.
I then give the patient serial calculations. 20 minus serial 3's; 100 minus serial 7's, which I hope at least most people in high school get to 86, but they don't seem to.
I then give the patient the word "world" and ask them to spell it backwards. I give them the word "truck" and ask them to spell that backwards. I then ask them for their phone number and then ask them to give me their phone number backward, and the image drawing part of the mini mental status exam is usually not something we do here because I don't find that useful in this sense.
We do the mini mental status exam minus two points. It's supposed to be calculated out of 30. Anybody 27 and above is considered normal, so we don't do the drawing part.

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Q Okay. So, am I correct in interpreting what you just told me in your note as meaning that the plaintiff was able to do everything you asked her to do from a mini mental standpoint, except she was only able to remember two of the three words you gave her?
A That is correct.
Q And did you assign a score to her mini mental?
A I did not, because I don't do the whole test, so it would be unfair to give her a 26, based on the fact that we don't do the drawing portion of the test. If I gave her 26, she would be abnormal.
Q But assuming that she was able to accomplish the drawing part of the test, she would have had a normal mini mental status score?
A Yes.
Q Under your assessment you have secondary insomnia. Do you know when that began?
A I don't know when it began. I know it was

presented to me on this visit.
Q I have a letter that you wrote to the administration on January 10th, 2013. Do you have that with you, Doctor?
A Yes.
Q And I think you kind of referenced this earlier. You were asking them to do a medical -- retroactive medical withdraw for her grades; correct?
A Correct.
Q And I'm pretty sure I know this, but why were you writing this letter to American University?
A She was having problems with American University dealing with the symptoms that she had had and the concussion that she had had, and she was not getting any relief from them for realizing that she had a medical condition, not allowing her to participate academically appropriately.
Q Do you know whether or not anyone at American University had attempted to make any accommodations for her academically?
A By her report to me, no accommodations were made, but I have not received anything back from

American University to let them tell me what they have tried to do.
Q Did the plaintiff ever tell you that her academic advisor encouraged her to withdraw from her classes in the spring of 2012, so she could focus on getting better and she refused?
A I have no knowledge of that, but I do know she can be stubborn.
Q What do you mean by that, Doctor?
A That she would say no, I can make it through, even though the odds were stacked against her currently.
Q Assuming hypothetically that she was off of all athletics, but she was insistent on trying to maintain her academics, could that cognitive stress of participating in academics exacerbated her long-term prognosis?
MR. NACE: Objection.
THE WITNESS: Our feeling is that if somebody is still symptomatic post-concussion, that any kind of overuse of the brain, whether it is from thinking, memory, balance, or any normal body function

that happens would be a stress and persist the symptoms of a post-concussion syndrome.
BY MR. MURPHY:
Q It's my understanding that the plaintiff went to -- out of the country for spring break in March of 2012. I know you mentioned that you were not aware of that, but assume that she did, can international travel have any negative impact on her recovery?
MR. NACE: Objection.
THE WITNESS: I'm sorry, I am feeling like strings are being pulled at.
Yes. Travel can cause these issues, but everything else we mentioned can also.
BY MR. MURPHY:
Q Sure. If Ms. Bradley had post-concussion syndrome and all the problems that she was reporting to you in that 2012/2013 time frame, is there any reason why that you would have abated and gone away entirely during a vacation and only to return when she comes back from vacation?
MR. NACE: Objection.
THE WITNESS: The lack of academic stress.

BY MR. MURPHY:
Q In your letter this January 10th, 2013 letter you talk about regarding to see improvement, what improvement are you referring to?
A She had some benefit on some of the medications we had tried her on with decrease in headache frequency, but she was still having concentration issues. We were still working on whether we wanted to put her on medications to help with her concentration.
Q Other than decreased frequency in headaches, was there any other improvement that you were starting to see by January 2013?
A I think some of her anxiety might have been alleviated with the medication as well. She still was having -- still was talking about sleeping issues and we ended up adding the third medication later to help with that.
Q The next follow-up visit is February 14th, 2013; is that correct?
A That is correct.
Q The History section is different now. All

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the language is different than your initial language that you had in the December visit. Is that because you just rewrote that History section without auto filling from before?

A That is correct.

Q Well, there is a number of I think new symptoms in here, at least as I look at the history you have on February 14th, 2013. From the history you had just done in December, and I guess my question is the new ones, are those things that she was reporting to you for the first time or was it your understanding that they had all been there prior?

A I think that they had been there and had become a little worse at this point in time. I think it's also a difference of she was getting used to me as a provider, so I was just getting more information, but these were, to me, something that had probably been present for a while and she just wasn't reporting.

Q Why with a diagnosis of post-concussion syndrome, would her symptoms get worse over a year after the initial onset of the concussion?

A Again, it could be based on the trauma. It could be based on stress. It could be based on the fact that they are actually permanent now, and the definition of concussion is no longer applicable.

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Q Could it be based on what the patient is doing on a day-to-day basis at that point in time?

MR. NACE: Objection.

You can answer.

THE WITNESS: If that is part of the stress that is harming her, yes, it is possible.

BY MR. MURPHY:

Q So under the history you talk about her noting significant improvement in her symptoms. Do you see that?

A Yes. That was with her visits to Dr. Neff, which included working with her neck and stuff like that, so that the headaches still had had a decreased frequency, although they were still present.

Q How about all the other problems, the dizziness, the mood, the anxiety, the visual disturbance, were they improving with the treatment by Dr. Neff?

A No, Dr. Neff's treatment was physical therapy only.

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Q Okay. I guess I'm trying to figure out how we know what symptoms were improving and what symptoms were not?

A Well, I had increased her Sertraline in the last visit, so I must have thought she needed more help, and the increase in Sertraline might have made improvement, but improvement does not mean resolution.

Q Sure. What is the significance of tolerating jogging without headaches?

A I think at that point was the first time that she had tried to do some physical activity. We find in concussion management that after a certain period of time, sometimes forcing an increase in low level physical activity will help the patient in resolution, and so we were probably looking at that as a possibility, so we probably had her consider trying to jog or do some light activity to see if she would tolerate that.

Q It then talks about her returning to running and possibly returning to field hockey. Did you have a discussion with her at that period of time whether that would be possible or a good idea?

A My comment probably was let's wait until we get you better.

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Q Okay. Under the Review of Systems section, and this is why I'm getting a little confused here, it looks like she denied having headaches, neck pain, dizziness and all these other things.

A A review of systems for me is something more of what's happening the day of the visit, versus the history of present illness, which is covering all things from the beginning of the illness, so the review of systems that day may have been that.

Q Okay. On this visit, February 14th, 2013, was there any objective signs of a problem going on with her during that examination?

A Yes. There were changes in her tracking, which is something she had noted in her symptoms for the history, and that would have been an issue.

Q Did you do any sort of testing to see if she was having any visual disturbance?

A I was looking for nystagmus, which is a tracking test.

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It looked like she was having some bouncing in her tracking and especially with rapid motions.

Q Was she having any testing for the visual disturbance?

A I was testing for nystagmus.

Q And is that -- I was going to ask you, is that down under Physical Findings?

A Yes.

Q Okay. So, where you have EOMI, what does that stand for?

A Extra ocular muscles intact.

Q Conversions at six to eight centimeters. What does that mean?

A That means you take the finger toward the head and see if the eyes will converge on the finger. Kind of makes the patient look a little cross-eyed, but them trying to the focus on a close object, do that was working at six to eight centimeters, which is appropriate. But the inappropriate part here was the saccades with tracking rapid motion, which means the eyes were bouncing as they got to the extremes looking laterally side-to-side.

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Q How do you actually track that or test that?

A You put the -- you essentially stabilize the head, and then you have them follow your index finger as you move it from side-to-side, and look at the eyes and see what the eyes are doing when it's following.

Q Did you recommend any treatment based on that finding?

A No treatment would be indicated, or there is no treatment specific. It's a finding. It's not a treatable event.

Q Okay. The other testing that you have under Physical Findings, is everything else there normal?

A Yes.

Q And then how did you change her medications on that visit?

A I'm not sure that we did, unless we added the Seroquel this visit, but I don't think we added that this visit. I think we added it before.

So she's on sertraline, which is a medication that has been shown to be useful in post-concussive treatment. We added Ritalin, which has been shown to be useful in increasing focus, even in people with head injury, and we added Seroquel to see if we could do better with her sleeping.

Q And her prescriptions, these are all 30-day prescriptions; correct?

A Correct.

Q So she would have run out of those prescriptions by mid March?

A Yep.

Q Did she have a follow-up visit scheduled with you for mid March to review her prescriptions?

A If she did, I have the next visit being in April.

Q Right.

A I mean, she could have called in for scripts or something like that.

Q Would you have any record of that in your system if new scripts had been called in?

A Let me see. Looks like we changed her -- this is in '13.

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Actually, her scripts from before were filled in to cover through April.

Q When were they set to expire?

A The one was -- looks like an expiration -- well, this is confusing, because it's the computer based on the date that you put it in. The one looked like it was supposed to go through April 10th, but that only goes based on the fact that the patient filled the prescription the exact day you gave them. So if she had leftovers and filled it two weeks later, it would have gone longer, and we don't get that information back from the pharmacy.

Q Sure. You said -- what medication was that?

A That was the sertraline and the Seroquel, and the Ritalin.

Q Okay. So they were all set to -- assuming she filled them the same day, they all would have run out around the same time?

A They all would have run out April 10th or afterwards, depending on what she already had with her?

Q Okay. All right.

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So then you next see her on April 18th of 2013; correct?
A Yes.
Q And who is ZD Martin, the medical assistant that took that history?
A That's Zack Martin.
Q And what did she report to Mr. Martin about her chief complaints?
A She said hit head on ground, and this was interesting. She didn't talk about that in her history of present illness.
Q Okay. So what are the details that she gave to Mr. Martin about her chief complaints and why she was there to see you that day?
A She was there mostly for follow-up of her concussion.
Q When Mr. Martin entered that she hit the back of her head on Saturday on the ground, was dizzy, dazed and lethargic, is that all consistent with her sustaining a new concussion?
MR. NACE: Objection.
THE WITNESS: I can't answer the question,

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because it's nothing that we ended up discussing during her exam, that she fell again.
BY MR. MURPHY:
Q So, how does this work? When the medical assistant takes the history, or the chief complaint, I'm sorry, where is that entered into the system?
A I may have gone into the room without seeing my computer first, so if he had entered it, I may not have seen it before I saw her.
Q Okay. Would it be important for you to have Ms. Bradley tell you the chief complaints she was having when you walk in the room and ask her how she's doing?
A Yes. I would have asked her how she was doing.
Q And wouldn't you have wanted to know if she had just hit the back of her head on the ground on Saturday and was dizzy, dazed and lethargic after it?
A If I had had that information, I would have wanted to know that, yes.
Q And I assume you would have taken a very detailed history as to exactly what happened; correct?

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A Okay. Well, I do have something in the here where she had an episode of loss of consciousness when transitioning from supine to standing position as she was doing her PT exercises at home, so that may have been that incident that she was talking about.
Q Well, do you know -- first of all, do you know if that is the same thing that she's talking about?
MR. NACE: Objection.
THE WITNESS: I have my history, sir. I can just read what I have written down here.
BY MR. MURPHY:
Q Okay. Assuming that she told you that she had an episode of loss of consciousness, would you have asked follow-up questions about how she was doing in the days, hours afterward, days afterward?
A Looks like I covered her history like that. Dizziness, visual loss when standing from sitting to supine, so she was still having symptoms there. Position when she was doing exercises. Still complaining of headaches, denied photophobia, which would have been a new question based on that situation,

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so it looks like I did try and cover that.
Q Okay. And if she had told you that she was feeling dizzy, dazed and lethargic, assuming that hitting of the head on Saturday is the same thing as the loss of consciousness she told you about, would you have documented those positive findings?
A I documented those findings. She had dizziness, visual loss when standing, when going from sitting to supine, or when she stands from sitting, or supine, so she's going from lying down to standing up, or sitting to standing up and she had one episode of loss of consciousness when transitioning from supine to standing, from lying down to standing, as she was trying to do her exercises, and that she did not have photophobia, still having headaches, still had visual disturbance with tracking. I mean, those things are in there. I think the order that I put them in there is probably not helping.
Q Okay. What is meant when you say last impact was at 99 percent?
A Impact testing is a test that we sometimes use from University of Pittsburgh Medical Center.

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Impact is a cognitive test originally put out in ways that we might be able to improve our management of concussions. We have found out that it is not useful and is not fared well in our literature, but we do sometimes use it too to help our hard cognitive testing measurements, and that indication of 99 percent was saying that memory issues had probably been resolving, which is a good sign.

Q So that's what I was trying to understand. Understanding that you may not use the impact score any more. Back at the time that you were using it, is it 99 percent a good thing or a bad thing?

A It's a good thing. It's a good thing for specific cognitive measures. It's essentially like taking my mini mental status exam and putting it on a computer and coming up with an objective score. So, it's a memory -- it's a memory and distraction test for thought processing, it is not for anything else.

Q With respect to the physical therapy she was doing, you talk about her having this loss of consciousness when doing her PT exercises and then you also talk about her working with Dr. Neff for physical

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therapy. What I'm trying to understand in this --
(Lost connection)
BY MR. MURPHY:

Q Was she still actively in therapy with Dr. Neff in April of 2013, or was she just doing home physical therapy exercises, if you know?

A Off the top of my head, I just don't know. I mean, even if she was active with Dr. Neff, she would still be doing exercises at home as part of her therapy.

Q If you look at the Review of Symptoms, other than headache and dizziness, did she have any other objective signs that she was reporting to you?

A She reported trouble with accommodation, which is trouble with focusing. Accommodation is kind of like are your eyeballs focusing on close or distance, and she was having trouble there. So those are the things that she reported specifically for that day, and headache.

Q Doctor, you froze up for a second. Can you hear me?

A Yes. She reported trouble with focusing,

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which is trouble with accommodation, and then she reported the headache. Those were again specific just for that day, for that visit.

Q Under your Assessment, you've added concussion on this visit. Do you see that?

A Yes.

Q That is something that you would have added; correct?

A Yes.

Q If you look at the note in its entirety, does it appear to you that she had sustained a new concussion in April of 2013?

MR. NACE: Objection.
You can answer.
THE WITNESS: It is possible. If she fell because of loss of consciousness, it's possible she hit her head and sustained a new concussion.
BY MR. MURPHY:

Q Well, can we agree that your assessment has changed to add concussion between your February 14th visit and your April 18th visit?

A Yes.

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Q Can we agree that you would not have written as part of your assessment in the April 18, 2013 concussion if it was not your opinion at the time that she had sustained a new concussion during that time frame?

A It's possible, yes.
Can I agree? Yes. I must have thought something to put that diagnosis back in the assessment.

Q That's what I thought. And I understand we are going back more than five years now, so I'm not trying to be critical of your memory, I'm just trying to interpret your notes. As you look at the April 18th note in its entirety with chief complaints given to Mr. Martin, her telling you the loss of consciousness during physical therapy exercises and assessment of a concussion, can we agree that the most probable interpretation of this note is that she sustained a new concussion in April of 2013?

A It is. Yes. I would say that that is what I was thinking.

Q Okay. I then have a letter the next day, April 19th, to Coach Jennings. This is what we

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referenced earlier; correct?
A Correct.
Q As I read this -- well, what is the purpose as to why you were writing this letter?
A I was mad. I think she was being mistreated.
Q Based on what she was telling you; correct?
A Based on what she was telling me that she was going to be allowed to maintain her scholarship only if she was a manager of the field hockey team.
Q Had you received any information at all from anyone at American University as to what their understanding of events were?
A I have not received anything ever from American University.
Q Did you ever speak with anyone at American University?
A I have not spoken with anybody from American University.
Q Was the plaintiff working while she was in Pennsylvania in the spring of 2013?
A I do not recall her working.

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Q What was it about being a team manager, which was going to be difficult for her?
A It is another stress to put on her brain for somebody who is still having symptoms from a concussive injury that was sustained a year and a half ago; even if there were a second injury afterward, she had had symptoms still going into that injury, otherwise she wouldn't have been doing the therapy.
Q Understanding that you may not have wanted her to be a manager, would there be alternative things that she might be able to do, like, you know, be a work study program or I'm thinking back to my college days where you had people sitting at the front desk signing students in and out of hallways or dorms, or other less stressful things that she might have been able to do to keep her scholarship?
A That was not my decision to make.
Q Okay. My question is a little bit different. Do you think that she was capable of doing some sort of work study program as of April 2013 when she returned to school?
A No. And I will take that to my part of the

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letter where I do say she is capable of returning to college. She will taking fewer credits to work back into school, but she has gone through an extensive amount of treatment there, physical therapy and medications to get to this point, and she should be able to maintain her scholarship, but she does not need anything else to burden her.
Q Assume hypothetically that she eventually returned to take full-time credits and do quite well with her scores, getting better grades post-injury than pre-injury. Is there any reason why she would not have been able to do any type of work study program before she graduated, but once she had gotten back to a full-time schedule?
MR. NACE: Objection, Counsel.
THE WITNESS: I'm sorry, sir, I can't answer the question.
BY MR. MURPHY:
Q Okay. Did you mention anything in the April 19th letter about a new concussion?
A I did not.
Q I'm assuming if someone has signs and

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symptoms consistent with post-concussion syndrome and they then sustain a new concussion, that can have further negative impact on their long-term prognosis; correct?
A You can make that assumption. I think we're making that assumption on the top of the fact that by this point in time, I don't consider what she had originally a concussion. I think that what we have to look at, as I get further onto this and started to make my decisions here, this girl has a traumatic brain injury. My definition, concussions resolve. This did not resolve.
Q All right. So, I will break that down, because I don't want to make any misassumption. As of April 18, 2013, your assessment of her was still post-concussion syndrome?
A Yes.
Q Okay. And later on your assessment does in fact change to include moderate traumatic brain injury; correct?
A Correct.
Q Okay. So now my question is focused on

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April 2013. If she has post-concussion syndrome as assessed by you, and then develops or sustains a new concussion on top of that, can that new concussion lead to her developing a more significant traumatic brain injury?

MR. NACE: Objection.

You can answer.

THE WITNESS: By my definitions the definition of moderate traumatic brain injury actually occurred at one year post-concussion, which was long before this occurred.

BY MR. MURPHY:

Q Assuming she has a moderate traumatic brain injury prior to April 2013, and then sustains a new concussion in April of 2013, can that new concussion make her condition worse?

MR. NACE: Objection.

THE WITNESS: Yes.

BY MR. MURPHY:

Q Look at your next note, Doctor, which I believe is May 16, 2013; correct?

A Yes.

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Q Under the Past Medical History it refers to physical trauma.

What is that referring to?

A That's probably referring to the trauma from her sport.

Q Okay. And under your assessment you still have concussion as well as post-concussion syndrome. Is the concussion still referring to the April 2013 incident?

A Probably.

Q Okay. And then let me make sure, is your next note, March of 2015, or did I miss something?

A Yes. You missed July of 2013, August of 2013, October of 2013.

Q During those 2013 visits, I think I probably just don't have them because nothing much changed. Can you just quickly go through those other 2013 visits and tell me if anything changed from a medical standpoint with her?

A We had an increase -- in the July visit she noted the mood had been stable. She was having trouble sleeping again. Continued to have mild headache every two to three days. Her tracking visually had improved, but it was still present at times of fatigue. The Adderall was helping with her focus and with her fatigue. She had finished physical therapy. Was having some problems with jaw tightness and temporal mandibular junction problems, so that was in there.

I think this kind of stuff you are going to see is just kind of bounced up and down for the next few months. We had stopped her sleep medicine. She was still on the Sertraline. She was no longer on the Seroquel. Still having trouble sleeping. The next history was not that much different. She did have a cough. She had some illness in there. She was then seen by one of my PAs for a follow-up and to talk about medications. She was not happy about having to be on medications all the time.

She was referred back to me to discuss this. I saw her again in November. She went back to college by then. Did have six credits. She saw somebody down in Philadelphia. I think she went down to a memory center or something in Philadelphia, and they had no change, except for more neuropsychological testing, which we had done previously through Dr. Bentz, and was still having difficulty sleeping.

Saw by my PA, and ended up with mono. Med check while doing that. A rash. This is now into 2014. The end of 2014 -- August of 2014 I saw her again. She had been to neurology at UPenn. They wanted to stop her medications, but she stated that she had been doing well since she was on the Adderall as needed. She said that her focus was improving coming on and off the medication. She was not using it regularly.

Q What medication was she not using regularly?

A Her Adderall, which is a stimulant. She started to feel she didn't need to use it, and she was going to go back to school and take 15 credits that fall.

Still gets headaches almost daily, but doesn't notice them as much anymore. Still gets dizziness with fast moving, with tracking, and she feels better that she has been able to do some more physical activity like yoga and biking.

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Q What was your -- I'm sorry, before you leave that October 22nd visit, I just --
A That's August 22nd.
Q I don't have that in front of me. What was your assessment.
MR. NACE: John, that was August 22nd.
MR. MURPHY: Yes. August 22nd, 2014; correct.
THE WITNESS: Yes. I was still putting down post-concussion syndrome because I think I was having hesitancy and wanting to call her a traumatic brain issue.
It's six in one, half dozen in another.
The next visit was March 11th, 2015. Here she reported feeling tired and poorly. Persistent symptoms, significant fatigue. Focusing was initially present. After the concussion had trouble focusing. Initially present after the concussion had initially been improving. Now she thinks she is having more difficulty focusing again.
Her memory she was reporting problems with. The headaches had been increased in duration. This is

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now since she's been through a semester of school. The brief pauses in headaches that she was having, she was not having again. She was having gynecological issues that I do not believe were part of her concussion or her head injury, and for the first time I put the diagnosis of traumatic brain injury into her assessment.
Q I was going to ask you about that. You don't qualify it mild or moderate. Is there a reason?
A Mild traumatic brain injury is a concussion, and then moderate traumatic is the next step up. These are permanent defects based on head injury.
Q And I guess what I'm trying to understand is you write traumatic brain injury on March 11, 2015. In your mind was it mild or moderate at that point?
A It's moderate.
Q And if I'm understanding you correctly, that is not based upon any new testing, that is just based upon the duration of the symptoms as she has reported them to you; is that fair?
A Yes. And the other side of this, our

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computer does not have the diagnosis moderate traumatic brain injury as a selection.
Q Okay. Fair enough.
Do you see her in between March 11th, 2015 and September 28, 2015?
A It looks like she was seen by me it was November -- November 28th, 2015. At that point in time she was getting ready to go to Nepal and she needed medication for elevations at times so we got her on some Diamox to help her deal with that.
Q I think you said November. I think you mean September 28 --
A Correct. September 28, 2015.
Q Did you have any discussions with her about whether or not she should be going to Nepal with a moderate traumatic brain injury?
A No. She told me she was feeling well and she was moving forward with her life despite these permanent deficits and I felt fine with that.
Q So what medication changes did you make for her based on her heading to Nepal?
A I did things that I would do for travelers.

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For elevation, we use Diamox or acetazolimide to deal with oxygen decreases as she goes into heights, and Cipro is something we give to travelers for diarrhea should she get it.
Q So that had nothing to do with her injury. That is what you would for anyone traveling abroad; correct?
A Correct.
(Lost connection)
BY MR. MURPHY:
Q Can her overseas travel exacerbate any of the problems she was experiencing that you are attributing to her injury?
MR. NACE: Objection.
THE WITNESS: If she were symptomatic and it was stressful, it could give her more symptoms. I don't have that indication that that occurred. I mean, getting up in the morning for somebody who has a traumatic brain injury can exacerbate their symptoms. But getting on with life is something that often is something you want to do for these people because they have already suffered enough, so I was hoping that she

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was just getting on with her life.
BY MR. MURPHY:
Q On your assessment on that visit you talk about normal routine, history and physical adult for travel.
What is that?
A Probably means that I signed a form saying that she was fit for travel.
Q You mention in your assessment on --
(Lost connection)
BY MR. MURPHY:
Q Doctor, I apologize if you answered the question. I did not hear it.
(Lost connection)
BY MR. MURPHY:
Q Why there is no mention of her traumatic brain injury or concussion on September 28th?
A Probably because that was not germane to her going on the trip.
Q Okay. Is the next time you see her June 1st, 2016 after she returned?
A Yes.

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Q Okay. Did she report any problems traveling in Nepal?
A She reported she had some difficulty with concentration and uncertain if she should go back on her medication. These are issues that developed with her moderate traumatic brain injury while in college. She would like to resume medication because of these continuing symptoms, so we resumed her medication.
Q Had she been without her medications while she was in Nepal?
A I would imagine that she was without or stopped them while she was there, and I did a -- I did not do a mini mental status today -- no, I did do one. I don't know why I have not in there, but I did do one because I said no disorientation, short-term memory was not impaired, registration was not impaired, no recall impairment. Calculation ability was not impaired, and balance was normal, and no nystagmus. The tracking issues and stuff like that, a lot of that had resolved, and her mini mental status was back to what I would consider normal.
Q Did she have any objective signs of an injury when you saw her on June 1st, 2016?

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A She did not have physical signs. She had reported history signs of headache and concentration still as issues which are obviously not something that you can see.
Q And if I'm reading this correct, you started her back on the Adderall at that time; is that correct?
A Yes.
Q I'm jumping ahead a bit to January 2nd, 2017. Do you have that report?
A January 2nd, 2017, yes.
Q Yes. Under your assessment on that day, you talk about her having attention deficit disorder; correct?
A Yes. That's probably based on her moderate traumatic brain injury.
Q That's the first time I believe that I have seen ADD come up in one of your assessments.
First of all, is that accurate?
A The diagnosis is accurate, yes.
Q Okay. Why was this diagnosis first being made on January 2nd, 2017?

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A The diagnosis had been made before and was just being used under the traumatic brain injury headline because she was having those issues based in that.
Q What was done to diagnose her with attention deficit disorder other than take the history from her?
A Her difficulty -- her history of concentration and difficulties there.
Q Was any kind of testing done for formal diagnosis of ADD?
A She had -- there was some of that noted in some of the neuropsych testing that she had had from before, so I would refer back to there, from Dr. Bentz, and I don't think I ever got the neuropsych testing from Penn. I don't think they ever sent it. But I mean, he had not noted the memory issues and concentration issues there, and you can tell when you talk with her, if you talk with her for too long, she's going to sway because it's going to fatigue her brain, and this kind of helps that from happening.

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Q The Adderall does?
A Yes.
Q Okay. I guess what I'm trying to understand is, is it your -- is it your understanding that someone else diagnosed her with ADD, or is it your understanding that you are the first one to diagnose her with that?
A I made the diagnosis prior to me putting the diagnosis in here, and I was using traumatic brain injury as the basis of that diagnosis.
Q Is there any way to tell whether or not she has ADD independent of the concussion?
MR. NACE: Objection.
THE WITNESS: She didn't have it before she went to school.
BY MR. MURPHY:
Q How do you know that?
A She was never medicated. She was never on anything before she went to school.
Q Do you know if she ever had any signs and symptoms of ADD and just hadn't been diagnosed prior to school?

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A I would imagine with her academic status coming out of high school, that that was not an issue.
Q What was her academic status coming out of high school?
A She was a good student.
Q Did you know her before her going to American University?
A I get all this from history.
Q I know you are a high school team physician, so I didn't know if you came across her at sporting events in high school.
A I don't cover the school that she went to.
Q You also have major depression on your assessment on this visit as well; correct?
A Yes. I think I'm differentiating out the aspects of her traumatic brain injury at this point so that other people will understand what I'm thinking about within the results of the traumatic brain injury.
Q All right. So then in layman's terms, how are you differentiating what she has related to a traumatic brain injury at this point in time?
A I don't know. I would have gone back to the

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emotional liability that she had talked about previously.
Q What do you mean by that, Doctor?
A She had talked about -- about feeling up and down previously in some of our visits, so I was probably still working from that.
Q The major depression, as you termed it, and the ADD, how much of that was caused by the April 2013 concussion that she sustained?
A She had both prior to that.
Q Even though it wasn't in your assessment?
A We talked about liability on those issues. You're talking -- you are taking two umbrella diagnoses that cover many things, so the post-concussion syndrome and now the traumatic brain injury are big umbrellas that cover a lot of different things. These things would have been included in those umbrellas.
Q What impact did the April 2013 concussion have on the big umbrellas or symptoms that she was suffering from?
MR. NACE: Objection.
THE WITNESS: Well, we noted that she had

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some increased symptoms after that April 23rd event, they were reported in the note.
BY MR. MURPHY:
Q Other than to say that the April 2013 concussion increased her symptoms, are you able to differentiate in any other way, what injury she sustained in April 2013?
MR. NACE: Objection.
THE WITNESS: I cannot differentiate, because she had a head injury to start with.
BY MR. MURPHY:
Q I'm looking now at your February 14th, 2017 note. Do you have that, Doctor?
A February 14th?
Q Of 2017.
A Yep.
Q The neck and back pain for seven months, you're not relating that to anything at American University, are you?
A No. I'm thinking -- I would relate those things if she was having more headaches, but she had these things before and did well with manual therapy so

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I referred her back to PT for that and sleeping -- she said she slept on a very bad bed when she was in Nepal.

Q Okay. I'm assuming that's what you were attributing it to, I just wanted to make sure.

A Yes. I have nothing to compare that to.

Q You also reference TMJ pain for five years. You are not relating any TMJ problems to American University, are you?

A If this is the result of her traumatic brain injury that she is having some anxiety and depression and she's clenching, I cannot relate them, but I cannot say it's a direct relationship.

When you take somebody with a traumatic brain injury and start extending them over a lifetime, that injury becomes and energy drain on the systems. She has to use extra energy to get around the deficits that she has cognitively or whatever is going on with the traumatic brain injury, so if she is using up all that energy and fatiguing out, she might be getting some of these symptoms, just based on that.

We're roaming into territories of yes, possibles.

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Q Okay. I'm not too concerned about possibles. I'm concerned more with probable and reasonable degree of medical certainty what is and what is not related.

My question first, your don't typically diagnose TMJ, do you?

A In my patient population?

Q Yes.

A Yes.

Q Wouldn't you typically refer patients with TMJ out to other specialists?

A Occasionally we'll refer them out to oral maxillary surgeons, if there is a surgical interest, but most of the time I try and treat them with bite blocks first to relieve pressure on the teeth. That's often very successful.

Q Did you give her any bite blocks?

A No.

Q Why not?

A I think she was seeing somebody else for it, to be honest with you. I think she had gone and seen -- she was seeing Dan for it. Dan and his physical therapy practice deals with TMJ.

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Q Without having -- well, strike that. Do you know if she had any history of TMJ problems prior to going to American University?

A I do not have that history.

Q That would be something important if you were going to try to relate TMJ to what happened at American University; correct?

MR. NACE: Objection.

THE WITNESS: That would be important for you, yes. For me it's just another thing to treat.

BY MR. MURPHY:

Q Okay. And if I'm following you correctly, Doctor, if she reports TMJ symptoms, you're going to treat it regardless of what the cause is, is that what you are saying?

A That is correct. That's why family doctor sits in front of sports medicine doctor.

Q All right. Got it. Bear with me.

You have not seen her since February 2017, have you?

A I saw her in April. April 7th of 2018.

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And this was not for a head injury event. That was for abdominal pain.

Q So -- I'm sorry. You broke up on me.

A That was for abdominal pain. That was not for a head injury event.

Q Okay. So I want to make sure I'm on the same page. Have you seen the plaintiff since February 2017 for anything related to her traumatic brain injury?

A I have not.

Q Do you have any knowledge of anyone else taking over her care related to the traumatic brain injury?

A I do not.

Q When is the last time all of her medications would have expired, related to the traumatic brain injury?

A I think she is over in Nepal, but the last time we prescribed anything for her focus and concentration was in March of 2018.

Q Okay. So, was that just a call-in prescription?

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A No. She had seen one of my PAs and asked for a refill at that time. She saw the PA for nausea and asked for a refill of medication while she was there.

Q When was the visit for nausea?

A 3/13/18.

Q So then in between February 2017 and March 2018, were there any medications called in for her or prescribed for her?

A It looks like she might have had a Vitamin D supplement, and gastritis, and we called omeprazole in for that.

Q Any of her medications related to a traumatic brain injury filled or called in between February 2017 and March 2018?

A Her Adderall was called in December 26th, '17.

Q Was that a 30-day supply of the Adderall?

A Based on the way this system handles controlled substances from the past, I can't answer that question.

Q Okay. What's the longest controlled

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substance like Adderall could be called in?

A Usually it's only 30 days at a time, but sometimes we write multiple prescriptions to send with the patient. Each prescription oftentimes cancels out the prescription in front of it, so we only ended up with that in our note. So if you look at the note from 3/13, there was one Adderall there. If you look at the note from 1/14, no Adderall there. From 12/26/17 there was Adderall there.

Q I guess what I'm trying to figure out, Doctor, is for that roughly year period, from February 2017 until she came in for nausea in March of 2018, other than the 30-day prescription for Adderall in December of 2017, can you say whether or not she had any other medication related to her brain injury prescribed?

MR. NACE: Objection.

THE WITNESS: Yes. She had it 11/28/17.

BY MR. MURPHY:

Q Was that Adderall?

A Yes. That's the easiest one I am finding at this point.

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Q Okay. What were the other medications that you were giving her for traumatic brain injury?

A She had stopped the Seroquel and she had stopped the Sertraline. We tried her on bupropion, but she didn't do well on that, so we stopped it.

We had tried amitriptyline back in the beginning, but she was agitated on that medicine, so it was a reaction, so we stopped it. But those are the only ones she's ever been on for her post-concussion syndrome, or traumatic brain injury.

Q Other than the medications that we just talked about, to your knowledge has she had any treatment for traumatic brain injury since February 2017?

A The refills of the Adderall that we talked about, but she's also been out of the country.

Q Right. And I'm still trying to figure out her travel schedule, but as far as you know, other than medications that we just talked about, has there been any other treatment for traumatic brain injury since February 2017?

A No.

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Q I know you are relating the traumatic brain injury to what happened at American University; correct?

A Yes.

Q And if I'm following you correctly, you are including within that umbrella ADD and depression; correct?

A Yes.

Q Anything else under the traumatic brain umbrella that Ms. Bradley is suffering from that you are relating to what happened at American?

A She occasionally has focusing issues with her eyes.

Q Are you able to quantify how often that comes and goes, other than when it's just referenced in your notes?

A Just from referencing in the notes. It's not something that she has complained about recently with our last visit, so I can't say more than that.

Q Okay. Anything else under the traumatic brain injury umbrella that she is suffering from, that you are causally relating to in this case?

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A Her entire life. I mean, I think we're missing that that umbrella covers a lot of things. So when she's tired, when she's fatigued, when she wears out because she talked for more than two hours, those kind of things, yes, that's the kind of things she's going to have.

Q If she has difficulty fatiguing after two hours and all these other problems, how is it that she's been able to negotiate and navigate throughout Nepal on her own for a long set of time?

A I would --

MR. NACE: Objection.

THE WITNESS: I would put that to personal fortitude.

BY MR. MURPHY:

Q Do you know if she's been able to learn any new languages?

A I don't.

Q Would someone with a traumatic brain injury typically be able to learn a new language?

A Yes.

Q And why wouldn't they be inconsistent?

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A I'm not understanding your question.

Q If someone has a traumatic brain injury, how would it be possible to learn a new language?

A She's not bereft of thought processing. We know she has memory. We know she has the capability of learning, because she learned in the end of her last two years at American University to get her degree.

Q What else is she able to do with the current injury status?

MR. NACE: Objection.

THE WITNESS: I can't predict the future for her, sir.

BY MR. MURPHY:

Q Is there any possibility that she will continue to improve with time?

MR. NACE: Objection.

THE WITNESS: Unable to say, sir.

MR. MURPHY: All right. Doctor, I have monopolized a lot of time. I want to look through my notes. I'm going to let other counsel ask some questions. I'm sure the other attorneys will have a few follow-ups. I may speed it up. Let me just take a look at my notes.

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THE WITNESS: Thank you.

EXAMINATION

BY MR. HAUGH:

Q Jeremy Haugh. I'm a Special Assistant with the United States Attorneys, and I'm representing the United States in this matter.

So I have a few questions and I may jump around a little bit, so just bear with me if you can.

I'm paraphrasing a little bit, but early on in your testimony, if you recall, you said that everything changed with regard to concussions with the first international consensus. When was that?

A I think it was -- it's either '06 or '09. I think it might have been 2006 and the second one was 2009.

Q Okay. And when you say everything changed, what changed with regard to --

A We essentially dropped our old system of grading concussions and giving specific time lengths for recovery, and realized that concussions was individual and every individual had to be treated in

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accordance with their symptoms.

Q Did the standard of care change?

A I believe yes.

Q How so?

A If you were using the old system, you weren't practicing standard of care.

Q When that change occurred, how long did it take for everyone to come to the new standard of care?

MR. NACE: Objection.

THE WITNESS: I find that the people that had the hardest time coming to the new standard of care were actually the neurologists, but I find that most of us in primary care sports medicine were very eager to get rid of that system, because it was full of holes, and full of inability to make sure that we were protecting the patient, so most of us in primary care sports medicine changed very quickly.

BY MR. HAUGH:

Q So by October 2011, had most people changed over to the new standard of care?

A I would hope so.

Q Do you know?

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MR. NACE: Objection.
THE WITNESS: I'm sorry, sir, I can't answer that question. I know our group had switched by 2006, 2007, based on the new information.
Q Okay. What specific criticisms do you have of Dr. Williams' treatment of Ms. Bradley?
A I was really upset with his differential diagnosis on her first visit that he thought sinusitis could be part of this problem, and that he ignored the fact she had a concussion because he did not know of a mechanism of injury that was specifically stated throughout the report.
Q If he had not known about what the mechanism of injury was, or had not seen that report, would that change your opinion of his diagnosis?
A No. Because one of the first things you should think about if you are taking care of an athlete is a head injury.
Q In your report you said that you found that Ms. Bradley had suffered a concussion as a result of a mechanism he identified in September 2011.
What mechanism are you referring to?

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A She said she was hit in the head by a shoulder of an opposing player.
Q If you had not known about that mechanism, would you still have diagnosed her with a concussion?
A Yes.
Q Why?
A Because you don't need to see the mechanism of injury to have the brain being sloshed around in the head to get a concussion.
Q What symptoms would show that there was a concussion?
A Every one that she listed. All the ones that she listed.
Q What were they?
A Dizziness, headaches, problems with focus, problems with balance, problems with memory.
MR. NACE: Jared, I believe the last question was what symptoms would you expect?
THE WITNESS: Yes.
MR. HAUGH: Yes.
BY MR. HAUGH:
Q What symptoms would mean that there was a concussion in someone? What symptoms would someone have to show for there to be a concussion?

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A Headaches, dizziness, decreased concentration, decreased focus, decreased ability to focus with vision, focus with mind, cognitive losses. All of those things fall into that.
Q What information did you have upon which you based your finding that she had a concussion in September of 2011?
A Her history.
Q Where did that come from?
A Her.
Q In your opinion, how important is it to get a complete medical history before you diagnosed someone?
A That was doing that. She came to us with a concussion diagnosis. We reviewed that concussion diagnosis with our history and concurred, and by that time she was in post-concussion range.
Q In your view, Doctor, how often is it that someone gives you a complete medical history in order to diagnose them?

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MR. NACE: Objection.
THE WITNESS: She gave us a medical history when she was here on her visit.
BY MR. HAUGH:
Q I understand that, but is it important for a doctor to receive a complete medical history prior to making a diagnosis?
MR. NACE: Objection, Counsel.
THE WITNESS: The answer academically is yes, it's always important to have a history before making a diagnosis.
BY MR. HAUGH:
Q If a doctor has an incomplete history, would they be able to make a correct diagnosis?
MR. NACE: Objection.
THE WITNESS: Can't answer that question, Counsel.
BY MR. HAUGH:
Q Well, just generally, as the doctor, if you have an incomplete medical history, does that make it more difficult to make a diagnosis?
MR. NACE: Objection.

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THE WITNESS: It makes it more difficult to make any diagnosis, but you can draw conclusions from her symptoms of a neurologic standpoint, hitting the primary issues and knowing that she was an athlete, that the likelihood is that these were from a concussion.

BY MR. HAUGH:

Q What role does a patient play in providing a complete medical history?

MR. NACE: Objection.

THE WITNESS: I assume that when I ask a patient a medical history, I'm getting an honest response.

BY MR. HAUGH:

Q In your opinion, has Ms. Bradley simply provided you with a complete medical history?

A Yes.

Q Going back to the causes that you or symptoms that showed that Ms. Bradley had a concussion, could they show any other -- can they show anything else? Could you diagnose her with anything else based on those symptoms?

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MR. NACE: Objection, but he can answer.

THE WITNESS: It would be some sort of central neurologic event, none of which were found because she had been scanned, MR'd, and all those other things, so again, this was put pushing us back to concussion.

BY MR. HAUGH:

Q You, in your view, based on your review of the records, do you believe this was a straightforward case of concussion from the beginning?

A Yes, I do.

Q And any doctor seen those symptoms should have diagnosed a concussion immediately?

A Yes, I do.

Q Do you know why it took -- there were three or four doctors in between who did not diagnose a concussion until Dr. Singh did?

MR. NACE: Objection.

THE WITNESS: I feel that I can't answer that question. The fact that it happened that long is really a sour taste in my mouth to those providers.

BY MR. HAUGH:

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Q When she came to you, she had already been diagnosed with post-concussion syndrome?

A Yes.

Q I said I would jump around and it made me think of this. On your note of 10/26/13 there is no mention of concussion, but it just says now post-concussion syndrome.

Do you know if that includes the post-April 2013 concussion? Does that make sense?

MR. NACE: Objection.

BY MR. HAUGH:

Q So if you go back to the note from 10/26/13 --

A Yes.

Q Under Assessment, concussion is not there, but post-concussion syndrome is.

A Correct.

Q In the notes prior to that, in between April 13th, and August of 2013, under Assessment, it said "concussion."

So, my question is, under the October 2013 note, does the post-concussion syndrome include the

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April 2013 concussion that you diagnosed?

MR. NACE: Objection. Asked and answered.

BY MR. HAUGH:

Q In other words, is she suffering from post-concussion syndrome as a result of the September 2011 concussion and the April 2013 concussion?

A There is no way to differentiate.

Q Okay. In your report you said that the records from American University confirmed and strengthened your opinions with regard to standard of care and causation. What records confirmed and strengthened your opinions?

A The athlete reported the symptoms to the trainer who immediately did a SKAT and reported them. The trainer did a SKAT a little bit later, but she should have been pulled immediately. Upon reporting symptoms she should no longer have been an active athlete. She should have been treated for concussion at that moment in time.

Q So who should have pulled her from --

A The athletic trainer and then the physician.

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Q So whoever got the information first should have pulled her?
MR. NACE: Objection.
THE WITNESS: Well, the chain of command in most of these places, is the athletic trainer gets the information and then gets it to the physician. The athletic trainer should have pulled the athlete from activity, taken the athlete to the physician, and then the physician should have qualified, confirmed, or denied that diagnosis.
BY MR. HAUGH:
Q So I just want to make sure I'm straight on this. As soon as they heard that she had those symptoms, the symptoms, dizziness, fatigue, lack of concentration, difficulty focusing, those things, as soon as anyone heard that, she should have been out?
A Yes, because she reported those things in reference to being hit in the head and that is in the athletic trainer's comments. It's on the SKAT form. Hit in the head. Three days later, five days later reported symptoms to the athletic trainer, should have happened then.

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Q Okay. But if the doctor doesn't know that she had been hit in the head, only that she is experiencing these symptoms, should he have then pulled her from playing?
A The doctor knew.
Q So you are basing your opinion on the fact that you're saying that Dr. Williams knew when he made his diagnosis that she had been hit in the head?
MR. NACE: Objection.
THE WITNESS: It was there on anything he should have been looking at to make his diagnosis, which would include the SKAT.
BY MR. HAUGH:
Q I'm just trying to be as clear as I can. So your opinion is based on your view that Dr. Williams knew that she had been hit in the head and he made his diagnosis?
MR. NACE: Objection.
THE WITNESS: I'm not sure what you are asking me to tell you.
BY MR. HAUGH:
Q On October 5th when Dr. Williams saw Ms. Bradley, do you believe that he was aware that she had been hit in the head?
A I do.
Q Do you base your opinion that he misdiagnosed her on that fact?
MR. NACE: Objection.
THE WITNESS: Based on his differential diagnosis list, I believe he missed it, yes.
BY MR. HAUGH:
Q Is one fact that you are basing your opinion on is that he knew she had been hit in the head?
MR. NACE: Objection, Counsel.
THE WITNESS: We just covered that it would take an entire history and physical to make a diagnosis, and now you're asking me to give a comment based upon one fact.
When he had the history and physical, which included hit in the head, and then an athletic trainer telling him he needed to see this person because of the symptoms, I think he should have been able to make the diagnosis of concussion.

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BY MR. HAUGH:
Q Okay. Maybe I'm just approaching it the wrong way.
Do you believe he knew that she was experiencing dizziness, fatigue, lack of concentration, difficulty focusing?
A I would believe he knew that, yes.
Q And based on the records, do you believe he knew or had been told that she had been hit in the head during the Richmond field hockey game in 2011?
A I believe he does, yes.
Q And are all those factors going into your opinion that he failed to diagnose a concussion?
MR. NACE: Objection.
THE WITNESS: Yes.
BY MR. HAUGH:
Q I just want to make sure you did answer yes to that question? There was an objection and I didn't hear.
A There was an objection, but he is allowing me to answer the question, and I believe that with all the information that was presented to the doctor in her

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visit with him, he should have -- he should have made the diagnosis of concussion.

Q When did you diagnose the moderate traumatic brain injury?

A I based that on the fact that she has continuing symptoms and deficits from a cognitive standpoint in focus and headaches that have lasted longer than a year, so I have no reason to believe that they are going to resolve.

With that, I can make the diagnosis of moderate traumatic brain injury.

Mild traumatic brain injury defines concussion, concussion by definition resolves. She has not resolved.

Q So when did she begin to have -- when did she stop having post-concussion syndrome and begin to have moderate traumatic brain injury?

MR. NACE: Objection.

THE WITNESS: It's a semantical issue within our field. I'm sorry, it's not that clear.

I defined it as a year.

BY MR. HAUGH:

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Q A year post-2011?

A Yes.

Q I'm sorry?

A Yes.

Q Okay. But you didn't diagnose it until 2015, or didn't appear in your record until 2015?

A I'm hesitant to put those things in records right off the bat because of how it can affect somebody's future in terms of insurance and things like that. I still was saying that she had a post-concussion syndrome, but anybody reading that, knowing the post-concussion syndrome is still being evaluated four years later, it is going to say this is not just post-concussion, this is traumatic brain injury.

Q Is the same true of the concussion that she received in April of 2013?

A That was --

Q That she is now experiencing moderate traumatic brain injury as a result of that concussion?

MR. NACE: Objection. Asked and answered.

THE WITNESS: She had by my definition a moderate traumatic brain injury one year after she sustained the concussion in American University because she was still symptomatic at that time.

The one that occurred in 2013 was after that and probably added to it, but what was there was already done.

MR. HAUGH:Okay. If you just give me one second, Doctor.

I appreciate your indulgence. At this point I don't have any further questions. Thank you, Doctor.

THE WITNESS: Thank you.

EXAMINATION

BY MR. MAYNARD:

Q Doctor, can you hear me? This is Rob Maynard?

A Yes.

Q All right. I represent Dr. Higgins. Per your report, it says that you only had criticisms of him to the extent that he was consulted or directly involved with the care and treatment.

Have you seen anything from what you have reviewed that makes you think that Dr. Higgins was involved with seeing Ms. Bradley in October 2011?

A Yes. I have the report of his differential diagnosis from that date of visit, which did not include concussion.

Q And when you say his report, tell me what you're talking about?

A This is back in August, the records that we have.

Q You can reference them over there?

A I can't -- I don't have them. Sir, that report sits in 13,000 pages of information somebody sent me to review for this, so I am fairly happy that I remembered that one, but to me that was the important one, because the important one was on his first evaluation of an athlete, presented to him by the athletic trainer, with symptoms of a concussion and a history of a hitting in the head, who was having persistent symptoms, this was a straight shot. Concussion should have been the diagnosis.

Q All right. Let me make clear. Again, I represent Dr. Higgins, not Dr. Williams, but I

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appreciate what you just told us.
Have you seen anything to show Dr. Higgins, who was charge of the fellows, Dr. Williams being one of the fellows, that shows Dr. Higgins knew directly about these visits that Jennifer Bradley was having?
A I can only comment on the physician that she had the visit with at American University, which I guess is Dr. Williams. I'm getting name-confused here.
Q No problem. Fair enough then. That's why we're here.
Do you have an opinion in this case, Doctor -- is there a point at which you can say that if Jennifer Bradley had -- had been held out from any further games or practices, to say that she would not have developed PCs, or moderate TBI?
MR. NACE: Objection.
You can answer that.
THE WITNESS: That's a difficult call. She could have developed a moderate traumatic brain injury from the hit, even if she had been held out, because once the hit was done, the damage was done and her genetic predisposition of head injury may have her move

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into that, but that is not something we know, nor can we predict.
BY MR. MAYNARD:
Q And I understand. We are just trying to find the universe of your opinions. If you don't have one on some of these issues, that is fine.
Do you have an opinion you are going to give or able to say, you know, this is the date at which we had not had her practice or play, she would not, more likely than not, have developed this?
MR. NACE: Objection.
BY MR. MAYNARD:
Q Again, if you can't give that, just say that.
MR. NACE: Objection.
MS. ROUTH: Objection.
THE WITNESS: I cannot give that as an exact.
BY MR. MAYNARD:
Q And you made a point to something earlier, about -- how you will recover. That is what you were hinting at. Something along the lines of a concussion

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is genetically determined?
A There is known genetic predetermination on how people recover from head injuries, yes.
Q Any opinion on some of the stats, like what percentage of people who, let's say, have a concussion will recover, even if they don't rest at all?
MR. NACE: Objection.
You can answer, Doctor.
THE WITNESS: I can't give you a percentage there.
BY MR. MAYNARD:
Q Okay. Any idea what percentage, even if you rest them, let's say at day one of a concussion or concussion symptom, will still get PCS? Is there a known incidence of PCS, no matter what?
A No. Because the problem is there is no way to look at this in a prospective double blind study, because we're not allowed to be teenagers in the head and see what happens to them.
Q Do you not think Dr. Cantu thinks the first 24, 48 hours, or the first week is the most important for purposes of having, you know, less chance of

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prolonged symptoms, if you will, or best recovery?
MR. NACE: Objection, Counsel.
THE WITNESS: I am sure Dr. Cantu believes that the earlier the diagnosis is made, improves the ability of having the athlete recover in a more complete fashion.
BY MR. MAYNARD:
Q Are you on board with that too?
MR. NACE: Objection, Counsel.
BY MR. MAYNARD:
Q I'm sorry. Do you ever agree with that?
A Do I agree that if you get the athlete early and make a diagnosis and remove them from activity in a very prompt fashion based on the time of their injury, I believe that we're making a better decision and improving their ability to recover.
Q In this case, do you have any opinion what would have happened if let's just say Jennifer Bradley, September 23rd -- let's say, starting then, didn't practice or play field hockey again, you know, from that moment on, what would have happened to her?
MR. NACE: Objection.

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BY MR. MAYNARD:
Q Do you have any opinion whether she would or wouldn't have had PCS or TBI?
MR. NACE: Objection, Counsel.
THE WITNESS: It's impossible to answer that question from a clinical standpoint.
BY MR. MAYNARD:
Q Is Jennifer Bradley still a patient of your practice?
A Yes, she is.
Q Do you know when she has any plans to see you guys again?
A I would assume upon when she comes back from Nepal.
Q And what kind of -- is she on a yearly physical schedule or a PRN schedule for, you know, any symptoms?
A At this point she's probably on an every six-month schedule, especially if she is still on any medications.
Q Somewhere in your notes, at some point, I'll see if I can nail the date, she had cervicalgia?

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A Neck pain, sir.
Q Is that related at all or under the umbrella, as you told us, of TBI?
A It may be a vicious cycle relationship there. People with TBI get headaches, people with headaches tighten up their neck, make their neck feel better, often helps their headaches go away. It's a vicious cycle event, sir.
Q So is that an opinion that in her case it is related, or it may be?
A My opinion is that it is related.
Q All right. Would you say as you went through all the treatment there, has she improved?
MR. NACE: Objection.
THE WITNESS: Okay. So we missed a year and a half of school because she couldn't think, concentrate, or physically make it through based on her head injury and she has gotten better, that she managed to finish school through going through everything that she received from us, as well as other doctors, yes, she has gotten a little bit better. She has also learned to live with the permanent deficits that she has left.
Q So you say it's both physically getting better and actually being able to -- you said cope or manage with whatever issues she has?
MR. NACE: Objection. That's not what his answer was, Counsel.
BY MR. MAYNARD:
Q Set me straight, Doctor. Go ahead.
A I believe it was a year and a half before she could even return to college and we got her back to returning to college through treatments, therapy, and everything that she went through. She then managed to graduate college and now she's managing to move ahead with a Master's Degree, so yes, she has gotten better, but the deficits that she still has, she has also learned to live with better.
I believe this girl has a strong fortitude, and is not going to give up her life based on an injury she sustained in field hockey in college, so I believe she is getting better, but she will always have these deficits at this point in time.
Q All right. And I was going to ask you her prognosis would be what?

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A I expert her to have deficits indefinitely.
Q I know you've said it, but my question on those issues, what would you say the deficits are that you say will last indefinitely?
A She will have chronic recurrent headaches, she will have difficulty with focus and concentration. She will have difficulty with memory at times.
Q Does indefinite mean permanent?
A Yes.
Q Maybe I covered this with my questions before. I assume you don't have an opinion -- let's say she stopped playing or practicing after she saw Dr. Williams, whether her outcome would be any different? Whether she had PCS or TBI?
A It is my personal belief that had she been pulled from activity early, we might have prevented this, but I cannot say that to 100 percent because sometimes it only takes one injury to change a person's life.
Q Right. That's why I'm saying, you're not able to give a date, September 23rd, if she stopped,

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October 5th, October 20th --
A No. It would have to have been a date more proximate to the time that she hit her head.
Q And you're saying even then there is this -- you can get moderate TBI just from a concussion, no matter what?
A Yes.
Q Any opinions -- do you intend to give any opinions on her ability to work, you know, pursue her Masters, what kind of job she can or can't get? Anything like that?
A I believe that she will be able to pursue these things, but I believe that she will have the difficulties associated with her traumatic brain injury.
Q Any literature that you have reviewed specific for your role here to give some opinions as an expert?
A I am constantly in review of literature for sports medicine, because that is my job, and the literature -- I did not review any specific literature for this.

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Q And then, can you tell me how did it happen that -- obviously as a -- you're a treating physician and your notes and your thoughts on that are of interest to us, how did it come up with Mr. Nace that you also said that you would have or give opinions on the care rendered?
A I mean, this is what I'm supposed to be very good at doing as a physician, and after 26 years and certifications by national standards and then being believed as a teacher of physicians and other people who provide healthcare, I do believe I have an excellent amount of experience to say that this is something I can do with very good capability.
Q Logistically, how did that come up? Logistically, how did that --
(Lost connection)
BY MR. MAYNARD:
Q When did that happen, if you remember?
MR. NACE: Mr. Maynard, you are just asking how and when did I contact him?
MR. MAYNARD: No. I mean, I saw your letter asking to contact. I'm just wondering when it

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came up, how it came up, you know, when he said he would give opinions about the care, if he remembers.
THE WITNESS: I mean, I have taken care of Jen since she presented to us with the diagnosis, and then the post-concussion diagnosis. I would assume that it came up when Jen gave my name to Mr. Nace as being a treating physician in this case.
BY MR. MAYNARD:
Q And do you remember any of your conversations with Mr. Nace?
A I reviewed my qualifications and I reviewed the fact that I am the treating physician.
Q And did he ask you do you have opinions about the care, or did you say to him, hey, I've got some issues with the care and I'm happy to speak to those?
A He asked me if I had opinions about the care and I gave my opinion.
Q That's all I was looking for.
Doctor, do you believe the attorneys asked so far, and there may be others, other follow-up, have covered all the opinions you intend to give at trial if

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asked?
A Yes.
MR. MAYNARD: All right. With that, I'll turn it over to whoever is next or whoever wants to follow up.
Thank you, Doctor.
EXAMINATION
BY MS. ROUTH:
Q This is Jen Routh on behalf of the NCAA.
Dr. Vollmar, have you ever served as an expert witness in litigation before?
A No.
Q And are you familiar with the NCAA?
A Yes.
Q To your understanding, what is the NCAA?
A It is the National Collegiate Athletic Association that helps govern the activity of college athletes, not only their games, you know, winnings and that kind of stuff, but also for their protection.
Q Are you aware that the NCAA is a defendant in this case brought by Jennifer Bradley?
A I am not.

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Q I assume that also means that you don't have any opinions with respect to the NCAA in this matter?
A No.
MS. Routh: Thank you.
EXAMINATION
BY MR. NACE:
Q Doctor, I just have a few very short questions.
You executed a report that we've gone over. You've had a chance to look at it. If you want to look at it again, is that report accurate?
A Yes.
Q Fairly reflects your opinions in this case?
A Yes.
Q And in that report it indicates at the very beginning that during the course of your treatment you formulated opinions regarding the care of Jennifer Bradley and the treatment of Jennifer Bradley, and then it also indicates that subsequently I contacted you and provided you additional records.
Is that accurate?

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A That is accurate.
Q Additional records that I provided to you, did they change your opinions in any way?
A No.
Q Did they support your opinions?
A Yes.
Q And we've gone over those opinions?
A That is correct.
Q Following up, we've talked -- we are talking a little bit about the standard of care for athletic trainers and for Dr. Williams. Just to speed this up, is this a national standard of care?
A It should be, yes.
Q And the standard of care in DC is the same standards as up in Pennsylvania; correct?
A Yes.
Q We also talked about the SKAT tests that were there, and that they increased, I think you said, roughly doubled on some things, but we have this test. Based off those tests, what did the standard of care require with regard to her return-to-play status?
A Return-to-play status is based on resolution of symptoms. We have had no moment in time so far in her care of the post-concussion case that was started with her injury at American University that she has ever resolved her symptoms.

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Q So when you said before in your testimony that once that SKAT 2 test was seen and showed the increase, she should have been held out of play. Is there anything that indicated that she should have gone back to play?
A No.
Q As a matter of fact, once they even suspected this was a diagnosis, she should have never have gone back to play.
A May I ask a question?
Q Sure.
A Does DC have the state law like Pennsylvania has?
Q We don't need to go into that.
You were asked and I just have to follow up. You were asked some questions about basing your opinion on the history given by the patient and I believe your answer was that you based your opinions on

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the history presented by Jennifer Bradley at your first visit, along with the prior diagnosis of post-concussion syndrome. Is that the routine practice in your field?
A If I am seeing a patient that is nearly four months post-injury, that would be the practice in my field, that I had been asked to render a more advanced treatment plan for somebody who is still having symptoms from a head injury received earlier that would be the standard practice in my field.
Q Okay. And then you spoke with Mr. Haugh for some time about the basis for your opinions, and he was asking about the symptoms as well as the knowledge of the mechanism of injury. Hypothetically, if Jen had not written down the mechanism of injury as being a shoulder to the head, given the symptoms that were presented to Ms. Earls and Dr. Williams, what does the standard of care require to be put on the differential diagnosis?
A Concussion.
Q So regardless of whether they knew the mechanism of injury or not, the standard of care still

required concussion to be on the differential?
A That's correct.
Q Regarding that, I think it was the April '13 notation of a concussion, and regarding -- could you look at that note again? I just want to make sure we are on this.
A When was it?
Q I believe April 18th, 2013.
A April 18th.
Q I think that's it. 2013.
A Yes.
Q Okay. According to that note, she had this episode of falling as a result of the therapy that she was doing because of the failure to diagnose the concussion in September of 2011; correct?
A Correct.
MR. NACE: That's all I have.
All done?
MR. MURPHY: I don't have any other follow-up.
MR. MAYNARD: I do not have any follow-up.
MR. HAUGH: This is Jeremy Hawk. I don't

have any follow-up either.
MR. NACE: Okay.
MR. MURPHY: Doctor, thank you very much for your time. I know it was a long deposition, but I appreciate you hanging in there with us.
MR. NACE: For the record, you have an opportunity to read the deposition. Just go through it and make sure there are no errors.
THE WITNESS: If somebody will get a copy to me, I will do that.
COURT REPORTER: Orders?
MR. MURPHY: Does everybody just want four to a page, mini E-tran?
MR. NACE: That's what I want.
MR. MURPHY: I'm making it easy for you, Ms. Reporter.
Four to a page, mini, E-tran, would be great.
MS. ROUTH: Me too.
(The deposition was concluded at 4:00 p.m.)

COMMONWEALTH OF PENNSYLVANIA)
COUNTY OF LANCASTER)
I, Pamela J. Dogger, a Notary Public of the Commonwealth of Pennsylvania, do hereby certify that the within-named witness personally appeared before me at the time and place herein set out, and after having been duly sworn by me, according to law, was examined by counsel.
I further certify that the examination was recorded stenographically by me and this transcript is a true record of the proceedings.
I further certify that I am not of counsel to any of the parties, nor in any way interested in the outcome of this action.

_____
Pamela J. Dogger, RPR and Notary Public
Commission Expires: August 2021

EXHIBIT

9

Professional Opinion on the Case Bradley versus American University
Tory R Lindley MA ATC

Foundation

I will testify to my education, training, employment history, professional service, clinical experience, certification and licensure as a Certified Athletic Trainer and healthcare administrator as contained in my curriculum vitae attached to supplement these disclosures. Additionally, my experiences also includes educating coaches on the signs and symptoms of concussion as well as policy and protocol related to concussion management.

I have reviewed the following documents, which have formed the basis for my opinions, in conjunction with my education, training, and professional experience.

- Plaintiff's Amended Complaint
- Plaintiff's Answers to Defendant AU's Interrogatories
- Emails Produced by Plaintiff
- Dr. Morris Records
- AU Medical Records
- AU Concussion Baseline Test
- Emails Produced by AU
- Educational Records
- AU Financial Assistance Records
- Athletics Compliance Office
- Georgetown University Hospital Records
- Dr. Diamantoni & Associates Records
- Deposition transcript of Jenna Earls
- Deposition transcript of Dr. Williams
- Deposition transcript of Sean Dash
- Deposition transcript of Coach Jennings
- Deposition transcript of Plaintiff
- Plaintiff's Expert Designation
- American University Field Hockey Box Scores

Athletic Training Education and Clinical Practice

Athletic trainers are healthcare professionals who work under the direction of physicians, as prescribed by state licensure statutes. The services provided by athletic trainers are comprised of prevention, emergency care, clinical diagnosis, therapeutic intervention and rehabilitation of injuries and

medical conditions. Athletic trainers become certified by earning a degree from an accredited athletic training curriculum that includes formal instruction in areas such as injury/illness prevention, first aid and emergency care, assessment of injury/illness, human anatomy and physiology, therapeutic modalities, and nutrition. Didactic learning is enhanced through clinical education experiences. Candidates are eligible to sit for a comprehensive exam administered by the *Board of Certification* (BOC). Once a candidate has their degree and passes the BOC exam they are nationally certified. Additionally, athletic trainers are licensed or otherwise regulated in 49 states, and the District of Columbia (California is the only state without credentialing requirements for athletic trainers.) To maintain their credentials athletic trainers must meet ongoing continuing education requirements.

Standards of Care in the Management of Sports-related Concussion

During the time that plaintiff, Ms. Bradley, participated as a collegiate field hockey athlete at American University, two documents set forth the standard of care for managing concussion. The initial document was the "National Athletic Trainers' Association Position Statement: Management of Sports-Related Concussion" published in 2004[1]. The second document was the "Consensus Statement on Concussion in Sport: the 3rd International Conference on Concussion in Sport" held in Zurich, November 2008[2]. Both of these documents provided evidence-based recommendations regarding the assessment techniques for the athletic trainer and physician, guidelines for referral of patients with concussions, when to either return the student-athlete to play or disqualify him/her from activity, equipment-related issues and consideration for younger athletes. Together NATA 2004 and Zurich 2008 provided specific recommendations for the athletic trainer, including objective assessment techniques and method to objectively conduct follow-up assessments to assist in making safe return-to-play decisions.

Athlete Duty to Report Symptoms

The issues related to concussions are as complicated and varied today, in 2018, as they were in 2011. Regardless, one thing is true today as it was in 2011 – a challenge that faces athletic trainers, regardless of the injury or the body part, is athletes' honesty with their caregiver as well as the timely and truthful reporting of their injury-related symptoms. A primary difference between concussion and other musculoskeletal injuries is the subjective nature of concussion-related symptoms. Moreover, studies available for over a decade have documented that student-athletes may not report all concussion-related symptoms because of a desire to return to play. Two studies have demonstrated student-athletes not reporting their concussion-related symptoms. In 2002 Delaney et al., and in 2004 McCrea et al, both found an underreporting of concussion symptoms. The Delaney study found over 70% of athletes failed to report their concussion symptoms, while similarly the McCrea study found over 50% of athletes surveyed admitted they did not report their concussion symptoms[3-4]. Both studies advocated better educational programs on the various aspects of concussions. Similarly, the 2011-12 NCAA Sports Medicine Handbook further noted in Guideline 2i that concussions "are often difficult to detect, with athletes often underreporting their injury, minimizing their importance or not recognizing an injury has occurred."[5]

Further, the National Athletic Trainers' Association Position Statement: Management of Sports-Related Concussion states "Perhaps the most challenging aspect of managing sport-related concussion is recognizing the injury, especially in athletes with no obvious signs that a concussion has actually occurred."[1] (pg 283). As noted in the research cited above, as well as in the NATA Position Statement, appropriate management of sport-related concussion begins with timely and truthful reporting of clinical symptoms; "[i]t is equally important for the athlete to understand the signs and symptoms of a concussion as well as the negative consequences (eg, second-impact syndrome and predisposition to future concussions) of not reporting a concussive injury"[1] (pg 284).

At the start of each season, Ms. Bradley's signature on American University's Concussion Statement acknowledged "I (Jennifer Bradley) have been provided with education on head injuries and understand the importance of immediately reporting symptoms of a head injury/concussion to the sports medicine staff." Further, she agreed "to report fully any problems related to my physical condition to appropriate university personnel." In this document, she acknowledges that "A concussion is a brain injury, which I am responsible for reporting to my sports medicine staff."

Also at the start of each season, Ms. Bradley's signature on American University's Acknowledgement of Risk form states: "To minimize the risk of injury, I agree to obey all safety rules, to report fully any problems related to my physical conditions to appropriate University personnel including medical personnel..." Finally, on a Department of Athletics form in August of 2011, Ms. Bradley's signature acknowledges that she "Understands that failure to disclose any or all medical problems and/or accurate medical history may result in loss of medical eligibility, forfeiture of athletics grant-in-aid and relieves the American University of any and all liability."

In direct conflict with these signed acknowledgments, at her deposition Ms. Bradley admitted that she did not report her symptoms from an injury sustained on September 23, 2011 until October 2, 2011 (there is a discrepancy in the plaintiffs' claim that she reported her signs and symptoms on October 1, 2011, versus the contemporaneous notes of the athletic trainer who documented that Ms. Bradley reported her symptoms on October 2, 2011). During the time that elapsed between injury and symptom reporting, she participated in field hockey practice and field hockey competitions. Subsequently, it would be extraordinarily difficult for the athletic trainers and coaches at American to appropriately care for Ms. Bradley.

The Standard of Care for an Athletic Trainer

A number of guidelines identify the scope of appropriate practice and standard to care for certified and licensed athletic trainers.

1. **BOC Practice Standards 1-7**

Standard 1- Direction: The Athletic Trainer renders service or treatment under the direction of, or in collaboration with a physician, in accordance with their training and the state's statutes, rules and regulations.

In the management of Ms. Bradley's injury, Ms. Earls acted in a way that was appropriate. When symptoms were reported to Ms. Earls on October 2, 2011 and October 3, 2012 via email, Ms. Earls coordinated a referral to an American University Team Physician, Dr. Williams.

Standard 2- Prevention: The Athletic Trainer implements measures to prevent and/or mitigate injury, illness and long-term disability

In the management of Ms. Bradley's injury, Ms. Earls acted in a way that was appropriate. During the game on September 23, 2011 there were no obvious collisions, mechanisms or outward signs or symptoms of injury sustained by Ms. Bradley that were missed by Ms. Earls.

Standard 3- Immediate Care: The Athletic Trainer provides care procedures used in acute and/or emergency situations, independent of setting.

In the management of Ms. Bradley's injury, Ms. Earls acted in a way that was appropriate. When symptoms were reported to Ms. Earls on October 2, 2011 and October 3, 2012 via email, Ms. Earls coordinated a SCAT2 test to be completed by Ms. Bradley.

Standard 4- Clinical Evaluation and Diagnosis: The Athletic Trainer utilizes patient history and appropriate physical examination procedures to determine the patient's impairments, diagnosis, level of function and disposition.

In the management of Ms. Bradley's injury, Ms. Earls acted in a way that was appropriate. When symptoms were reported to Ms. Earls on October 2, 2011 and October 3, 2012 via email, Ms. Earls coordinated a referral to an American University Team Physician, Dr. Williams. In deposition Ms. Earls stated that she suspected a concussion and her responsibility was to refer Ms. Bradley to a team physician (Dr. Williams) for assessment and diagnosis. It would be unprecedented for an athletic trainer to override a physician's diagnosis.

Standard 5- Treatment, Rehabilitation and Reconditioning: In the development of a treatment program, under the direction of a physician, the AT determines appropriate treatment, rehabilitation and/or reconditioning strategies.

In the management of Ms. Bradley's injury, Ms. Earls acted in a way that was appropriate. When symptoms were reported to Ms. Earls on October 2, 2011 and October 3, 2012 via email, Ms. Earls coordinated a referral to an American University Team Physician, Dr. Williams. Following the October 5, 2011 examination and diagnosis from Dr. Williams, Ms. Earls carried out the treatment plan as described and indicated on the documentation of the October 5, 2011 physician visit. It would be unprecedented for the athletic trainer to override the physician's plan of care.

Standard 6- Program Discontinuation: The AT, with physician collaboration recommends discontinuation of the AT service when the patient has received the optimal benefit.

This standard is not applicable in this case.

Standard 7- Organization and Administration: Services are documented as a part of the patient's permanent records.

In the management of Ms. Bradley's injury Ms. Earls acted in a way that was appropriate. Ms. Earls documentation in American University's Sportsware system met or exceeded standard of care.

2. **BOC Code of Professional Responsibility**

1.5 Communicates clearly and truthfully with patients and other persons involved in the patient's program appropriate discussion of assessment results, program plans and progress

In the management of Ms. Bradley's injury, Ms. Earls acted in a way that was appropriate.

3.3 Collaborates and cooperates with other healthcare providers involved in a patient's care

In the management of Ms. Bradley's injury, Ms. Earls acted in a way that was appropriate including her collaboration and cooperation with the Dr. Williams.

3.4 Respects the expertise and responsibility of all healthcare providers involved in patient care

In the management of Ms. Bradley's injury, Ms. Earls acted in a way that was appropriate including her interaction with Dr. Williams as her directing physician. Further, she assisted in the follow-up care

including coordinating evaluation and treatment of Ms. Bradley by multiple medical specialist and sub-specialists.

3. **State Regulation-**

Under the Health Professional Licensure act in Washington DC[7], the practice of athletic training is defined as *"(2A-ii)(A) "Practice of athletic training" means any of the following: "(i) The treatment of an athletic injury that is: "(I) For an athlete whose condition is within the professional and educational ability of the licensed athletic trainer; and "(II) Performed under the general supervision of a physician who has issued any written order, protocol, or recommendation for an athletic injury; "(ii) The immediate treatment of athletic injuries, including common emergency medical situations; "(iii) The provision of education, guidance, and counseling to athletes, coaches, parents of athletes, and athletic communities regarding athletic training and the prevention, care, and treatment of athletic injuries; and "(iv) The organization and administration of athletic training programs.*

In the management of Ms. Bradley's injury, Ms. Earls acted in a way that was appropriate including acting under the supervision of Dr. Williams who issued a diagnosis for Ms. Bradley as well as a protocol and plan of care in this case.

4. **NATA Code of Ethics**

1.2 Members shall be committed to providing competent care.
3.2 Members shall provide only those services for which they are qualified through education or experience and which are allowed by their practice acts and other pertinent regulation.
3.3 Members shall provide services and make referrals for those services that are necessary.
4.1 Members should conduct themselves personally and professionally in a manner that does not compromise their professional responsibilities or the practice of athletic training.

In the management of Ms. Bradley's injury, Ms. Earls acted in a way that followed the NATA Code of Ethics including timely physician referral and action under the supervision of Dr. Williams who issued a diagnosis for Ms. Bradley as well as a protocol and plan of care in this case.

5. **National Standards:** Position Statements and Consensus Statements

In the management of Ms. Bradley's injury, Ms. Earls acted in a way that was appropriate according to the national standards as described on page two of this opinion report.

Actions of the Coaching Staff

The primary role of the Head Coach and Assistant coaches is to refer all injury and medical issues to the athletic trainers or physicians. Like other NCAA Division 1 programs, the coaches have immediate availability or on-call availability to an athletic trainer. It is expected that Coach Jennings should defer medical decisions to the athletic trainers. The National Athletic Trainers' Association Position Statement: Management of Sports-Related Concussion[1] states "Coaches should be informed that in situations when a concussion is suspected but an ATC or physician is not available, their primary role is to ensure that the athlete is immediately seen by an ATC or physician." In this case, Coach Jennings demonstrated compliance with nationally recognized standards for a coach's role in concussion management.

Coach Jennings and his staff would be expected to follow the physician plan of care, which they did in this case. Coach Jennings and staff would be expected to follow institutional protocols related to concussion management, which they did. Finally, based on testimony, Coach Jennings went above and beyond by providing transportation for Ms. Bradley to some of her medical appointments.

Summary Opinions

- If her deposition history of concussion is accurate, Ms. Bradley failed to report her injuries or symptoms to American University healthcare providers in a timely fashion. This late reporting of symptoms would make if extraordinarily difficult for the athletic trainers and coaches at American University to care for Ms. Bradley.

- The athletic trainers at American University, including Ms. Jenna Earls, met the standard of care for appropriate assessment of Ms. Bradley with an injury history by referring her to be examined by Dr. Williams on October 5, 2011.
- In the management of Ms. Bradley's injury, the athletic trainers at American University, including Ms. Jenna Earls, met standards of care according to BOC Practice Standard, BOC Code of Professional Responsibility, NATA Code of Ethics, and national position statements and consensus statements. Further:
    - Ms. Earls respected the expertise and responsibility of all healthcare providers involved in Ms. Bradley's care.
    - Ms. Earls acted in support of the patient's best interest and was an advocate for the Ms. Bradley's health and safety.
- The coaching staff, including Coach Jennings, acted and complied with nationally accepted coaching practices related to concussion management.

References

1. Guskiewicz KM, Bruce SL, Cantu RC, et al. National Athletic Trainers' Association Position Statement: Management of Sports-Related Concussion. *J Ath Train* 2004; 39(3): 280-297.
2. McCrory P, Meeuwisse W, Johnston K, Dvorak J, Aubry M, Molloy M, Cantu R. Consensus Statement on Concussion in Sport: the 3rd International Conference on Concussion in Sport held in Zurich *Clin J Sport Med*. 2009;19:185-200
3. Delaney JS, Lacroix JV, Leclerc S, Johnston KM, Concussion among university football and soccer players. *Clin J Sport Med*. 2002;12(6):331-338
4. McCrea M, Hammeke T, Olsen G, Leo P, Guskiewicz K. Unreported concussion in high school football players: Implications for prevention. *Clin J Sport Med*. 2004;14(1):13-17
5. National Collegiate Athletic Association. Concussion or mild traumatic brain injury (mTBI) in the athlete. In: Klossner D, ed. *2011-2012 NCAA Sports Medicine Handbook*. 22nd Edition. NCAA, 2011.
6. D.C. Code Section 3-1201.02 (2014). Prior to 2014 the District did not regulate athletic trainers.

Prior Cases Testified and Fee Schedule

Westendorf v. Tuttle, et. al. 2008.

Fee schedule $265/hr.

I hold the above opinions within reasonable degree of professional certainty. I reserve the right to supplement my opinions should further information become available.

Submitted on May 29, 2018

Tory Lindley ATC

Tory Lindley MA ATC